WAGE RATES FOR NURSING FACILITIES PERSONNEL

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

H.R. 1649

A BILL TO AMEND TITLE XIX OF THE SOCIAL SECURITY ACT TO REQUIRE NURSING FACILITIES PARTICIPATING IN THE MEDICAID PROGRAM TO PAY, ON A PHASED-IN BASIS, NURSING PERSONNEL AT A RATE AT LEAST EQUAL TO THE MEAN RATE PAID NURSING PERSONNEL EMPLOYED OUTSIDE NURSING FACILITIES

JULY 20, 1990

Serial No. 101-180

Printed for the use of the Committee on Energy and Commerce

U.S. GOVERNMENT PRINTING OFFICE

36-338⇆ WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

JAMES H. SCHEUER, New York
HENRY A. WAXMAN, California
PHILIP R. SHARP, Indiana
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
AL SWIFT, Washington
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
W.J. "BILLY" TAUZIN, Louisiana
RON WYDEN, Oregon
RALPH M. HALL, Texas
DENNIS E. ECKART, Ohio
BILL RICHARDSON, New Mexico
JIM SLATTERY, Kansas
GERRY SIKORSKI, Minnesota
JOHN BRYANT, Texas
JIM BATES, California
RICK BOUCHER, Virginia
JIM COOPER, Tennessee
TERRY L. BRUCE, Illinois
J. ROY ROWLAND, Georgia
THOMAS J. MANTON, New York
EDOLPHUS TOWNS, New York
C. THOMAS McMILLEN, Maryland

NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
WILLIAM E. DANNEMEYER, California
BOB WHITTAKER, Kansas
THOMAS J. TAUKE, Iowa
DON RITTER, Pennsylvania
THOMAS J. BLILEY, Jr., Virginia
JACK FIELDS, Texas
MICHAEL G. OXLEY, Ohio
HOWARD C. NIELSON, Utah
MICHAEL BILIRAKIS, Florida
DAN SCHAEFER, Colorado
JOE BARTON, Texas
SONNY CALLAHAN, Alabama
ALEX McMILLAN, North Carolina

John S. Orlando, *Chief of Staff*
John M. Clough, Jr., *Staff Director*
Margaret A. Durbin, *Minority Chief Counsel/Staff Director*

Subcommittee on Health and the Environment

HENRY A. WAXMAN, California, *Chairman*

JAMES H. SCHEUER, New York
RON WYDEN, Oregon
GERRY SIKORSKI, Minnesota
JIM BATES, California
TERRY L. BRUCE, Illinois
J. ROY ROWLAND, Georgia
EDOLPHUS TOWNS, New York
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
RALPH M. HALL, Texas
DENNIS E. ECKART, Ohio
BILL RICHARDSON, Mew Mexico
JOHN D. DINGELL, Michigan,
(Ex Officio)

EDWARD R. MADIGAN, Illinois
WILLIAM E. DANNEMEYER, California
BOB WHITTAKER, Kansas
THOMAS J. TAUKE, Iowa
THOMAS J. BLILEY, Jr., Virginia
JACK FIELDS, Texas
HOWARD C. NIELSON, Utah
MICHAEL BILIRAKIS, Florida
NORMAN F. LENT, New York
(Ex Officio)

Karen Nelson, *Staff Director*
Ruth J. Katz, *Counsel*
Andreas G. Schneider, *Counsel*
Mary Margaret McGrane, *Minority Counsel*

CONTENTS

WAGE RATES FOR NURSING FACILITIES PERSONNEL

FRIDAY, JULY 20, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:50 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

Our hearing this morning is on H.R. 1649, legislation introduced by Congressman Walgren to improve the wages and benefits of nurses and nurse aides working in nursing facilities that participate in Medicaid.

This bill speaks to an issue critical to the quality of care for nursing facility residents. If wage and benefit levels are not adequate, then nursing facilities will not be able to recruit and retain the nurses and nurse aides in the numbers and of the caliber needed to deliver quality care.

Because Medicaid is the single largest payer for nursing facility care, its reimbursement policies have a major impact on the revenues of many nursing facilities, and on the ability of those facilities to compensate adequately, the workers who provide hands-on care to residents. The Walgren bill would phase in a requirement that States, under their Medicaid programs, pay nursing facilities the costs of raising wages and benefits for direct care nursing personnel at a level equal to the mean of rates paid in that locality to nursing personnel providing comparable services in hospitals and settings other than nursing facilities.

The purpose of this morning's hearing is to learn more about the bill and how it would work from nurses, nurse aides, residents, facilities and State Medicaid agencies.

Without objection, I would like to insert in the record at this point the text of H.R. 1649 and a copy of the cost estimate done by the Congressional Budget Office.

[The text of H.R. 1649 and the cost estimate follow:]

101ST CONGRESS
1ST SESSION

H. R. 1649

To amend title XIX of the Social Security Act to require nursing facilities participating in the medicaid program to pay, on a phased-in basis, nursing personnel at a rate at least equal to the mean rate paid nursing personnel employed outside nursing facilities.

IN THE HOUSE OF REPRESENTATIVES

MARCH 23, 1989

Mr. WALGREN introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend title XIX of the Social Security Act to require nursing facilities participating in the medicaid program to pay, on a phased-in basis, nursing personnel at a rate at least equal to the mean rate paid nursing personnel employed outside nursing facilities.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. MINIMUM WAGE RATE FOR NURSING PERSONNEL IN NURSING FACILITIES.

(a) MINIMUM WAGE RATE REQUIREMENTS.—Section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by inserting "and" at the end of subparagraph (E); and

(3) by adding at the end the following new subparagraph:

"(F)(i) in making payment for nursing facility services under the plan, for payment of the costs (attributable to individuals receiving medical assistance under the State plan) of wages and benefits of the facility's nursing personnel (including nurses' aides) who provide or supervise direct care of residents at a rate that is at least equal to the minimum rate of wages and benefits established under subsection (s)(1) for nursing personnel in a locality in the State;

"(ii) for recovery by the State (through offset or otherwise) from a nursing facility of such amounts as are paid to the facility pursuant to clause (i) but are not expended by the facility for wages and benefits of nursing personnel described in such clause; and

"(iii) that the State shall—

"(I) for the period consisting of the 4 calendar quarters that ends at least

180 days before this subparagraph is effective in the State, conduct a survey to determine, through a statistically representative sample, the mean rate of wages and benefits paid in each locality in the State to nursing personnel (including nurses' aides) who provide, in nursing facilities, nursing services described in clause (i) to individuals receiving medical assistance under the State plan,

"(II) for periods consisting of the 4 calendar quarters that end at least 180 days before each period described in subsection (s)(1), conduct a survey to determine, through a statistically representative sample, the mean rate of wages and benefits paid in each locality in the State to nursing personnel (including nurses' aides) who provide, outside nursing facilities, nursing services comparable to those described in clause (i),

"(III) report to each nursing facility in a locality in the State on the mean

rates of wages and benefits determined under subclauses (I) and (II) for that locality, and

"(IV) report to the Secretary on the mean rates of wages and benefits determined under subclauses (I) and (II) for each locality in the State;".

(b) COMPUTATION OF MINIMUM WAGE RATE.—Section 1902 of such Act is further amended by inserting after subsection (r) the following new subsection:

"(s)(1) Except as provided in paragraph (2), for the purposes of subparagraph (F) of subsection (a)(13), the minimum rate of wages and benefits for nursing personnel in a locality in the State—

"(A) for the first 4 calendar quarters in which such subparagraph is effective in the State, is 66.5 percent of the base rate plus 33.5 percent of the adjusted rate,

"(B) for the next 4 calendar quarters in which such subparagraph is effective in the State, is 66.5 percent of the base rate plus 33.5 percent of the adjusted rate,

"(C) for the next 4 calendar quarters in which such subparagraph is effective in the State, is 33.5

percent of the base rate plus 66.5 percent of the adjusted rate,

"(D) for the next 4 calendar quarters in which such subparagraph is effective in the State, is 33.5 percent of the base rate plus 66.5 percent of the adjusted rate, and

"(E) for each succeeding period of 4 calendar quarters in which such subparagraph is effective in the State, is 100 percent of the adjusted rate.

"(2) If during any period described in paragraph (1), the base rate is greater than the adjusted rate, for the purposes of subparagraph (F) of subsection (a)(13), the minimum rate is the base rate.

"(3) As used in this subsection—

"(A) the term 'base rate' means the rate determined for the locality under subsection (a)(13)(F)(iii)(I), and

"(B) the term 'adjusted rate' means the rate determined for the locality for the appropriate period under subsection (a)(13)(F)(iii)(II).".

(c) TRANSITION.—For the purposes of the amendment made by section 1(3), for periods ending before October 1, 1990, any reference to "nursing facility services" shall be deemed a reference to "skilled nursing facility services" and "intermediate care facility services".

SEC. 2. INCORPORATING REQUIREMENTS INTO STATE PLAN.

(a) EFFECTIVE DATE.—The amendment made by section 1(3) applies to payments under title XIX of the Social Security Act for calendar quarters beginning with the first calendar quarter that begins more than 180 days after the date of the enactment of this Act, without regard to whether regulations to implement such amendment are promulgated by such date.

(b) STATE PLAN AMENDMENTS.—If an amendment to a State plan for medical assistance under title XIX of the Social Security Act is necessary for compliance with the requirements of section 1902(a)(13)(F) of such Act (as added by section 1(3) of this Act), then the State shall submit such amendment to the Secretary of Health and Human Services not later than 90 days after the date of the enactment of this Act. The Secretary shall, not later than 180 days after the date of the enactment of this Act, review each such plan amendment for compliance with such requirements and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such amendment, the State shall immediately submit a revised amendment which meets such requirements. The absence of approval of such a plan amendment does not relieve the State or any nursing facility of any obligation or requirement under title XIX of the Social Security Act.

○

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

October 27, 1989

1. BILL NUMBER: H.R. 1649

2. BILL TITLE: None.

3. BILL STATUS:

As introduced in the House of Representatives on March 23, 1989.

4. BILL PURPOSE:

To amend title XIX of the Social Security Act to require nursing facilities participating in the Medicaid program to pay, on a phased-in basis, nursing personnel at a rate at least equal to the mean rate paid nursing personnel employed outside nursing facilities.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

	(by fiscal years, in millions of dollars)				
	1990	1991	1992	1993	1994
Estimated Budget Authority	185	845	1,190	2,095	2,600
Estimated Outlays	185	845	1,190	2,095	2,600

The costs of this bill fall within budget function 550.

Basis of Estimate

The estimate is based upon the portion of Medicaid's nursing facility reimbursement currently attributable to nursing services. According to sources at the American Hospital Association and the American Health Care Association (AHCA), approximately 45 percent of nursing facilities' revenue is expended on nursing personnel wages and benefits. Thus, in 1990, approximately $7.1 billion of the $15.8 billion expected Medicaid expenditures for nursing home services will be spent on nursing wages and benefits.

According to AHCA's Wages and Benefits survey of 1988 and the National Sample Survey conducted by the Health Resources and Services Agency of the Public Health Service, the overall wage differential between nursing staff in nursing home settings and other facilities was 31 percent in 1988. The overall differential was calculated by weighting each of the wage differentials for nurses aids, licensed practical nurses, and registered nurses by the approximate number of nurses in each of these categories. Under this proposal, Medicaid's spending for nursing personnel would then increase in 1990 by 31 percent from approximately $7.1 billion to $9.3 billion. The cost of this legislation would be the difference between current expenditures and the estimated expenditures or $2.2 billion in 1990, growing with inflation to $2.6 billion in 1994. However, due to a gradual phase-in of the bill over the course of sixteen calendar quarters, the full differential would not be in effect until 1994.

6. ESTIMATED COST TO STATE AND LOCAL GOVERNMENT: The federal government pays an average of 56 percent of the total cost of the Medicaid program. State and local governments fund the remaining 44 percent. Applying this distribution to the costs of H.R. 1649, the state and local costs would be approximately $150 million in 1990, increasing to $2.1 billion in 1994.

7. ESTIMATE COMPARISON: None

8. PREVIOUS CBO ESTIMATE: None

9. ESTIMATE PREPARED BY: Jean Hearne (226-2820)

10. ESTIMATE APPROVED BY:

James L. Blum
Assistant Director
for Budget Analysis

Mr. WAXMAN. When Congressman Walgren introduced this bill in March of last year, he was a member of this subcommittee. Of course, earlier this year, he became the Chairman of the Subcommittee on Commerce, Consumer Protection, and Competitiveness. We have asked him to join us this morning as both an alumnus and an author. I would like to recognize him at this point for any opening remarks he would like to make.

Mr. Walgren.

Mr. WALGREN. Thank you very much, Mr. Chairman, and I particularly appreciate the time and attention that you have given this bill that I introduced, and I especially appreciate the opportunity to come and join with you today as you hear testimony about it.

I have introduced this legislation to make salaries of nursing staff in nursing homes comparable to nursing staff in other health care facilities, because I believe that, despite the reforms in staffing levels and training requirements that were so important and so needed, that we put into law in 1987, we all know that the attention nursing home patients receive today and will receive as those reforms are brought into being will remain minimal.

Nursing home patients are sick, they are disabled, and yet when we look at the amount of time and attention they receive from professional health care personnel, we find that registered nurses spend on average only 12 minutes a day per patient in nursing homes. In hospitals, the hands-on attention is much greater, 45 minutes per patient per day.

Forty percent of nursing homes report their registered nurses have contact for only 6 minutes or less per patient per day. Hands-on care to patients is minimal because nursing home staffs are stretched to the limit, and wage and benefit rates do not attract well-trained quality personnel.

Many are committed and many are compassionate employees. They have to be able to withstand the kinds of difficulties that they confront hour by hour in nursing homes. But while attracting and retaining committed, competent personnel depends on many factors, the one factor that cannot be overcome is a failure in salary comparability to other kinds of nursing situations.

Seven hundred thousand people provide nursing home care in nursing homes. Twelve percent are registered nurses. Seventeen percent are licensed practical nurses. Seventy-one percent are nurse aides. Ninety percent of the care is given by nurse aides alone.

Most nursing homes report a shortage of nursing personnel and the staff turnover is something that cannot be believed, let alone managed. From 60 to 90 percent of staff turn over every year.

The 1988 HHS study shows that earnings of registered nurses who work in general duty nursing and nursing homes are only 82 percent of hospital registered nurses. Licensed practical nurses' salaries show wide disparities.

In Detroit, licensed practical nurses earn 23 percent less than comparable hospital nurses. nurse aides, men and women who really are on the front line in these facilities, earn from $3.65 an hour in Houston, to $8 or so an hour in New York, a difference of 143 percent.

I would like to submit for the record, Mr. Chairman, an excellent compilation of data on wages prepared by Richard Price of the Congressional Research Service as background.

Mr. WAXMAN. Without objection.

[Testimony resumes on p. 28.]

[The CRS compilation referred to follows:]

Congressional Research Service
The Library of Congress

Washington, D.C. 20540

July 16, 1990

TO : Honorable Doug Walgren
Attention: Glenda Booth

FROM : Richard Price
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : **Information on Nursing Home Staff**

This is in response to your request for information on issues raised by your bill, H.R. 1649, that would require the nursing staff of nursing homes to be paid minimum wage rates established according to procedures outlined in the bill. You requested this information as background for a hearing scheduled for your bill July 20. Specifically, you asked for (1) the most current comparative information on salaries of nursing personnel in various practice settings; (2) innovative approaches used by nursing homes and States to increase salaries of nursing home staff and to retain and attract persons to work in nursing homes; and (3) potential problems and other comments on with H.R. 1649.

SUMMARY OF H.R. 1649

H.R. 1649 would require State Medicaid plans to include in their reimbursements to nursing homes payment for the wages and benefits of nursing personnel at rates that are at least equal to the mean rates paid nursing personnel employed *outside* nursing homes. The bill would require that all nursing personnel who provide or supervise direct care of Medicaid nursing home residents be paid this minimum rate.

For purposes of determining the mean wage and benefit rates to be paid by Medicaid, States would be required to conduct a statistically representative sample survey of the wages and benefits of nursing personnel within nursing homes as well as the wages and benefits of nursing personnel who work outside nursing homes and who provide services comparable to those provided by nursing home personnel. These surveys would be conducted so as to determine the mean rate of wages and benefits to be paid in each locality of the State. After they are established, the new wage and benefit rates for nursing home personnel would be phased in over a period of 5 years. States would be required to recover from Medicaid nursing homes amounts paid for

but not used by the facility for the new wages and benefits of nursing home personnel.

NURSING STAFF IN NURSING HOMES

The National Center for Health Statistics conducts periodic surveys of nursing homes and their residents and staff. The latest of these surveys, known as the National Nursing Home Survey (NNHS), was conducted in 1985. According to the 1985 NNHS, there were 19,100 nursing homes in the country in 1985. These homes had 1,624,200 beds and 1,491,400 residents, for an occupancy rate of nearly 92 percent.

Almost all nursing home beds--nearly 90 percent--were certified for participation in Medicare and/or Medicaid as skilled nursing facilities (SNFs) or intermediate care facilities (ICFs). Table 1 indicates that 1.4 million of the 1.6 million nursing home beds in the country were certified for participation in Medicare and/or Medicaid in 1985. The largest portion of certified beds were certified as both SNFs and ICFs (724,000). Smaller shares were certified as SNFs only (307,900) or ICFs only (409,400). Only 182,900 beds were not certified for participation in Medicare and/or Medicaid in 1985. Unfortunately, the NNHS did not collect data on certification status in such a way as to isolate those beds which are certified for Medicaid participation only.[1] However, a survey conducted by the National Governors' Association for the Congressional Research Service in 1987 found approximately 1.3 million nursing home beds certified for participation in Medicaid. Table 2 shows total Medicaid certified beds for the nation as a whole as well as for each of the States. From this table, it would appear that most certified beds are certified for participation in Medicaid.

---

[1]Those beds that are certified as SNFs may particpate in either Medicare or Medicaid or both. As table 1 indicates, some beds are certified as both SNFs and ICFs. Since Medicare does not cover ICF care, those beds certified as ICF only would be certified for participation in Medicaid only.

TABLE 1. Certification Status of Nursing Homes and Nursing Home Beds, 1985

Certification status	Nursing homes		Nursing home beds	
	Number	Percent distribution	Number	Percent distribution
Total certified and uncertified	19,100	100.0	1,624,200	100.0
Certified facilities	14,400	75.4	1,441,300	88.7
Skilled nursing facility only	3,500	18.3	307,900	19.0
Medicare and medicaid	2,200	11.5	226,100	13.9
Medicare	800	4.2	43,800	2.7
Medicaid	*	*	38,000	2.3
Skilled nursing facility (SNF) and intermediate care facility (ICF)	5,700	29.8	724,000	44.6
Medicare SNF, and medicaid SNF and ICF	3,900	20.4	537,300	33.1
Medicaid SNF and ICF	1,700	8.9	180,700	11.1
Medicare SNF and medicaid ICF	*	*	*	*
Intermediate care facility only	5,300	27.7	409,400	25.2
Not certified	4,700	24.6	182,900	11.3

* Figure does not meet standards of reliability or precision.

NOTE: Figures may not add to totals due to rounding.

Source: *The National Nursing Home Survey: 1985 Summary for the United States.* Data from the National Health Survey, Series 13, No. 97. National Center for Health Statistics. DHHS Publication No. (PHS) 89-1758.

TABLE 2. Number of Medicaid-Certified Nursing Home Beds by, State, 1987

	Total certified nursing home beds
Total	1,291,136
Alabama	21,650
Alaska	646
Arkansas	21,356
California	111,073*
Colorado	16,976
Connecticut	NR
Delaware	3,729
D.C.	4,584
Florida	47,683
Georgia	32,319
Hawaii	2,821
Idaho	4,813
Illinois	NR
Indiana	47,926
Iowa	33,200
Kansas	26,393
Kentucky	18,647
Louisiana	32,595
Maine	NR
Maryland	23,705
Massachusetts	47,187
Michigan	37,851
Minnesota	46,984
Mississippi	13,882
Missouri	33,491
Montana	6,646
Nebraska	17,036
Nevada	2,745
New Hampshire	6,979
New Jersey	36,945
New Mexico	6,047
New York	99,506*
North Carolina	NR
North Dakota	6,821
Ohio	78,866
Oklahoma	28,706
Oregon	14,837*
Pennsylvania	80,967
Rhode Island	9,571

TABLE 2. Number of Medicaid-Certified Nursing Home Beds by, State, 1987--Continued

	Total certified nursing home beds
South Carolina	15,213*
South Dakota	7,773
Tennessee	26,403*
Texas	94,866
Utah	6,692
Vermont	3,412
Virginia	21,693
Washington	26,205
West Virginia	9,417
Wisconsin	52,000
Wyoming	2,279

NOTE: **"Total certified nursing home beds"** includes beds in facilities certified for participation in Medicaid as skilled nursing facilities (SNFs), intermediate care facilities (ICFs), or both. Except as noted, it does **not** include intermediate care facilities for the mentally retarded. The **TOTAL** is given for reporting States only.

Data was reported during the second quarter of 1987, but the date of the actual count was not specifically requested and was therefore not reported by most States. Where a State indicated that the reported count dates from earlier than 1986, an asterisk appears. Dates for these States are given in the individual State notes below.

***Individual State Notes**

NR: Not reported.

California data pertain to 1985.

New York data are from Dec. 31, 1984.

Oregon's bed total includes all licensed beds. A new State law will require all beds in a certified facility to be certified. This is expected to result in virtually all beds in the State becoming certified. Most facilities are certified as both SNF and ICF.

South Carolina's bed total includes intermediate care facilities for the mentally retarded.

Tennessee data pertain to 1985.

Source: U.S. Library of Congress. Congressional Research Service. *Medicaid Eligibility for the Elderly in Need of Long Term Care.* CRS Report for Congress No. 87-986 EPW, by Edward Neuschler. Prepared under contract No. 86-20. Washington, Sept. 1987. p. 24.

The NNHS found that nursing homes employed a total of 1.16 million full-time equivalent employees (FTEs) in 1985. Of this total, about 61 percent, or 704,300 FTEs, were nursing personnel. The NNHS divided nursing personnel into three categories: registered nurses, licensed practical nurses, and nurses' aides and orderlies. Registered nurses amounted to 12 percent of total nursing personnel; licensed practical nurses amounted to 17 percent; and nurses' aides the remaining 71 percent.[2] The great bulk of care provided in nursing homes is provided by nurses' aides. The Institute of Medicine has estimated that as much as 90 percent of resident care in nursing homes is delivered by aides.[3]

EARNINGS OF NURSING STAFF WORKING IN NURSING HOMES AND OTHER SETTINGS

Earnings of Registered Nurses

The most current and comprehensive comparative salary data for nursing personnel working in a variety of health care settings was collected in 1988 by the Division of Nursing of the Public Health Service. This survey was limited to registered nurses (RNs). Table 3 presents average annual earnings of RNs employed full-time in a number of different practice settings.

In 1988, average full-time earnings of registered nurses for all settings was $28,383. For RNs working in nursing homes/extended care facilities, average earnings were $25,351, or about 11 percent less than the average for all RNs. Another way of expressing this difference is in terms of a ratio. In 1988, nursing home RN average earnings were 89 percent of average earnings for all RNs. A slightly larger differential exists when average earnings for RNs in nursing homes are compared to average earnings of hospital RNs. Nursing home RNs had average earnings that were 13 percent less than

---

[2]Strahan, Genevieve. Nursing Home Characteristics: Preliminary Data from the 1985 National Nursing Home Survey. *Advance Data.* No. 131, Mar. 27, 1987. p. 6.

[3]Institute of Medicine. *Improving the Quality of Care in Nursing Homes.* Washington, National Academy Press, 1986. p. 90.

hospital RNs. In other words, average earnings of nursing home RNs were 87 percent of hospital RNs.

Table 3 shows that nursing home RNs have average earnings that are consistently less than earnings for RNs in other settings. Average earnings for nursing home RNs who work as staff or general duty nurses were 82 percent of earnings of hospital RNs working in similar positions. For nursing home RNs working as supervisors, average earning were 80 percent of hospital RNs working as supervisors.

It should be noted that this table assumes that the work of RNs is comparable across these various settings. In fact, qualitative differences may exist to justify earnings differentials. For instance, hospitals have a more complex hierarchy of registered nurse staff and responsibilities for this staff than nursing homes where there may be only one or two RNs employed. The averages probably reflect this.

In addition, the use of *average* earnings may mask considerable variance in earnings in one practice setting that does not exist for another. For example, a sizable number of RNs may earn a good deal less than the average that is indicated in the table, and in another setting, most nurses may be clustered close to the average. The Division of Nursing could not supply us this information; however, analysis of earlier survey data on RN earnings found a larger proportion of RNs in nursing homes earning lower salaries than RNs in hospitals.[4] Moreover, *average* earnings may also hide considerable geographic variation in earnings across health care settings.

Finally, these averages are for earnings only. They do not deal with differences in benefits, such as vacation time, health insurance, where there may also be considerable variation. The Division of Nursing did not collect comparative information on benefits of RNs working in various health care settings.

---

[4]Secretary's Commission on Nursing, Final Report, v. 1, Dec. 1988. p. 3.

TABLE 3. Average Annual Earnings of Registered Nurses Employed Full-Time in Their Principal Nursing Position, by Field of Employment and Type of Position March 1988

Field of employment	Total[a]	Administrator or assistant	Consultant	Supervisor	Instructor	Head nurse or assistant	Staff or gen. duty nurse
Total	$28,383	$34,564	$31,768	$29,528	$30,517	$30,428	$25,263
Hospital	29,160	33,905	30,993	31,207	31,753	31,475	27,196
Nursing home/extended care facility	25,351	27,601	35,018	25,186	25,184	25,208	22,381
Nursing education	31,329	41,050	-	-	30,335	-	[b]
Community/public health	26,702	32,108	30,358	27,352	[b]	[b]	23,635
Student health service	23,581	[b]	-	[b]	27,412	[b]	22,460
Occupational health	29,115	34,225	[b]	30,822	[b]	[b]	27,389
Ambulatory care setting	24,809	34,091	[b]	27,261	[b]	23,723	21,520

[a]Includes all registered nurses in positions not separately identified as well as those itemized separately.

[b]Too few to compute average.

Source: Unpublished data, Division of Nursing, Bureau of Health Professions, Public Health Service, Department of Health and Human Services.

Earnings of Licensed Practical Nurses and Nurses' Aides

The most recent *comparative* data for earnings of the two other categories of nursing personnel employed by nursing homes--licensed practical nurses (LPNs) and nurses' aides--was collected in 1985 by the Bureau of Labor Statistics (BLS), Department of Labor. This data was collected by BLS for two settings, the hospital and nursing and personal care facilities. This data is part of a comprehensive survey of earnings of a broad range of professional and nonprofessional personnel employed in hospitals and nursing homes. BLS collected hospital wage data in 23 metropolitan statistical areas and nursing home wage data in 22 areas.[5]

Table 4 shows average hourly earnings of LPNs working in hospitals and nursing homes in 1985. The table shows a wide varation in hourly earnings for both hospital and nursing home LPNs across the Nation. For nursing home LPNs, the lowest average hourly earning rate was $6.20 in Atlanta and the highest rate was $10.92 in New York, a difference of 76 percent. There was also a good deal of variation across the country in the ratio of the earnings of nursing home LPNs to hospital LPNs. This ratio ranged from .77 in Detroit to 1.11 in New York. In other words, in Detroit nursing home LPNs earned on average 77 percent of hospital LPNs, or 23 percent less. In New York, on the other hand, the average hourly earnings of nursing home LPNs were actually greater than the earnings of hospital LPNs. Clearly New York is the exception in this survey, with every other area showing lower earnings for nursing home LPNs than for hospital LPNs.

Table 5 shows the average hourly earnings of nurses' aides working in hospitals and nursing homes. A similar wide variation in hourly earnings exists for both hospital and nursing home aides. The lowest average rate was $3.65 in Houston and the highest was $8.87 in New York, a difference of 143 percent. This table also shows a wide variation in the ratio of hourly earnings of nursing home aides to hospital aides. What is particularly striking about these ratios, however, is the large disparity they reveal in the earnings of nursing home aides as compared to hospital aides. Nursing home aides earned on average 53 percent of the hourly rate of hospital aides in San Francisco. Thirteen of the areas surveyed by BLS show nursing home aides earning less than 70 percent of the hourly rate of hospital aides.

---

[5]While BLS has collected more recent earnings data for hospital employees, it has not collected nursing home earnings since 1985.

TABLE 4. Average Hourly Earnings of Full-Time Licensed Practical Nurses, 1985

	Hospital	Nursing and personal care facilities	Ratio of nursing home LPN to hospital LPN hourly earnings
Boston	$9.16	$8.51	.93
Buffalo	7.68	6.31	.82
New York	9.82	10.92	1.11
Philadelphia	8.73	8.23	.94
Atlanta	7.20	6.20	.86
Baltimore	8.64	7.50	.87
Dallas-Ft. Worth	7.53	7.38	.98
Houston	8.08	7.14	.88
Miami	8.50	7.71	.91
Washington, D.C.	8.87	8.34	.94
Chicago	8.80	7.18	.82
Cleveland	8.93	7.58	.85
Detroit	9.39	7.20	.77
Kansas City	8.10	7.20	.89
Milwaukee	8.40	7.95	.95
Minn.-St. Paul	8.96	8.66	.97
St. Louis	8.51	6.79	.80
Denver	9.01	7.54	.84
Los Angeles	9.62	8.50	.88
Oakland	10.79	8.86	.82
Portland	8.91	N.A.	--
San Francisco	10.80	8.79	.81
Seattle	8.33	7.58	.91

Source: U.S. Dept. of Labor. Bureau of Labor Statistics. *Industry Wage Survey: Nursing and Personal Care Facilities, September 1985.* Bulletin 2275, Mar. 1987; U.S. Dept. of Labor. Bureau of Labor Statistics. *Industry Wage Survey: Hospitals, September 1985.* Bulletin 2273, Feb. 1987.

TABLE 5. Average Hourly Earnings of Full-Time Nurse Aides 1985

	Hospital	Nursing and personal care facilities	Ratio of nursing home aide to hospital aide hourly earnings
Boston	$6.70	$5.36	.80
Buffalo	6.09	4.77	.78
New York	8.70	8.87	1.02
Philadelphia	7.64	4.98	.65
Atlanta	5.62	3.85	.69
Baltimore	6.53	4.56	.70
Dallas-Ft. Worth	5.43	3.85	.71
Houston	5.79	3.65	.63
Miami	6.38	4.70	.74
Washington, D.C.	7.21	4.68	.65
Chicago	7.06	4.43	.63
Cleveland	7.17	4.52	.63
Detroit	7.06	4.01	.57
Kansas City	5.72	4.10	.72
Milwaukee	6.83	5.04	.74
Minn.-St. Paul	7.01	6.37	.91
St. Louis	6.47	4.08	.63
Denver	7.11	4.19	.59
Los Angeles	7.09	4.51	.64
Oakland	9.50	5.30	.56
Portland	7.24	N.A.	--
San Francisco	9.76	5.21	.53
Seattle	7.26	4.68	.64

Source: U.S. Dept. of Labor. Bureau of Labor Statistics. *Industry Wage Survey: Nursing and Personal Care Facilities, September 1985.* Bulletin 2275, Mar. 1987; U.S. Dept. of Labor. Bureau of Labor Statistics. *Industry Wage Survey: Hospitals, September 1985.* Bulletin 2273, Feb. 1987.

CRS-12

EFFORTS BY NURSING HOMES AND STATES TO ATTRACT AND RETAIN NURSING STAFF OF NURSING HOMES

In order to determine what approaches nursing homes and States were using for increasing the salaries and benefits of nursing staff and for retaining nursing personnel, we contacted a number of organizations, including the American Association of Homes for the Aging, the National Citizens Coaltion for Nursing Home Reform, the American Health Care Association, the Association of State Medicaid Directors, the National Governors' Association, and the Intergovernmental Health Policy Project. These organizations cited the following examples.

Some States have enacted wage pass-throughs for increases in nursing salaries. For example, in 1988 California increased Medicaid nursing home payment rates to reflect additional labor costs incurred as a result of an increase in the State's minimum wage law. Other States, such as Illinois and Michigan, have increased their nursing home rates in order to increase wages of nursing staff. In 1989, Maine passed a law which prohibited the State's Medicaid nursing home prospective payment system from setting ceilings on payments made for wages and benefits of nursing personnel. In essence, Maine took the wage component for nurses out of its prospective payment system and reimbursed nursing homes for the actual costs they incurred for the wages of licensed nurses and nurses' aides.

Benefits offered at the nursing home are important considerations in recruiting and retaining personnel. Important benefits include the potential for salary increases, employer contributions to health benefits coverage, vacation time, and on-site day care. These observations from the organizations mentioned above correspond to findings of the 1985 NNHS on responses of RNs to questions about factors which would encourage continued employment in nursing homes. See Attachment 1.

Career ladder programs are also important, especially for nurse aides. These can include training to enable the aide to provide more specialized care as an aide. Some nursing homes give both wage increases and professional recognition for the attainment of new skills. Career mobility programs can also include tuition support for aides to become licensed practical nurses or licensed vocational nurses. In these programs, the nursing home typically provides tuition support to aides who agree to stay on staff for a period of time after becoming licensed.

Nursing homes have also learned that involving all levels of nursing staff, including aides, in the provision of care improves retention. This team approach has also been effective in retaining staff where it extends to the development of plans of care.

Some nursing homes have found that the way care is provided can have an impact on the morale and retention of staff. For example, some homes have decreased the use of restraints and have found that this change has

established a more dynamic atmosphere in the home. Patients are more active, staff have more care-giving responsibilities, and staff report being more satisfied with their jobs.

COMMENTS ON H.R. 1649

H.R. 1649 would require States to increase payments to nursing homes for the higher wages and benefits that would have to be paid to nursing personnel providing care to Medicaid beneficiaries. This may be a major concern for the States, since it would likely result in significant additional spending under their Medicaid plans. Tables 1 and 2 above indicated that most nursing home beds are certified for participation in Medicaid. During the reconciliation process in 1989, States expressed concern about the budgetary impact of some of the new Medicaid requirements that were included in pending bills. Medicaid accounts for the second largest component of aggregate State spending, after education.[6]

States are also particularly concerned about their spending for nursing home care under Medicaid. As a proportion of total program spending for all beneficiaries, Medicaid expenditures for nursing home care amounted to almost 30 percent of total spending in 1988. In addition, beginning October 1, 1990, States face the need to increase spending for nursing home care as the result of new requirements that become effective under nursing home reform legislation passed in 1987. Among these is a requirement that nursing homes participating in Medicaid upgrade the amount of licensed nursing care they have on duty during the day.[7]

---

[6]Telephone conversation with the National Association of State Budget Officers.

[7]One of the main differences that distinguishes the requirements for SNFs participating in Medicare and Medicaid from those for Medicaid ICFs is the licensed nurse staffing requirement. Medicare has required that SNFs have on duty 24 hours a day licensed nurses, including the services of a registered professional nurse at least during the day tour of duty 7 days a week. Licensed nurses include registered nurses or practical and vocational nurses licensed by the State in which they practice. Certain rural SNFs may receive a waiver from the Health Care Financing Administration (HCFA) for the registered nurse requirment for a 48-hour period. The nursing home reform legislation contained in the Omnibus Budget Reconcilation Act of 1987 (OBRA 87) retained these same licensed nursing requirements for SNFs participating in Medicare. Effective Oct. 1, 1990, SNFs must provide 24-hour licensed nursing care and must use a registered professional nurse at least 8 consecutive hours a day 7 days a week (with waivers permitted for the registered nurse requirement for certain rural facilities).

For ICFs, on the other hand, Medicaid has only required that a licensed nurse be on duty on the day shift 7 days a week. This licensed nurse could

(continued...)

States are also likely to find problematic your bill's requirement that they conduct surveys of wages and benefits of nursing personnel in a variety of work settings in various localities of the State. Because States do not currently conduct such surveys, this could involve significant new effort and expense for them.

Table 5 showed particularly large differentials in earnings of nursing home aides as compared to hospital aides. Data do not exist to indicate whether differentials as large as these still exist today. However, the competition nursing homes face for recruiting nurses' aides is not simply from other health care settings. Hospitals, home health care agencies, and nursing homes alike have indicated that they have had difficulty recruiting aides because service businesses such as fast food chains pay more than they do.

A number of States (including Connecticut, Illinois, Maryland, Minnesota, Nebraska, New York, Ohio, and West Virginia) use case-mix adjustments in their reimbursement rates for Medicaid nursing home patients. Case-mix adjustments translate patients varying service needs into specific reimbursement rates that result in higher payment rates for patients who cost more to serve and lower payment rates for patients who cost less. Case-mix adjustments could enable nursing homes to offer more attractive salaries and compete more effectively for nursing personnel.[8] A number of States have been considering adopting case-mix adjustments for Medicaid nursing home patients, and others are expected to do so with the implementation of nursing home reform legislation this year and the elimination of the distinction between SNF and ICF level of care under Medicaid. Nursing home reform

---

[7](...continued)
be a registered nurse or a licensed practical or vocational nurse. As a practical matter, this requirement would allow ICFs to use nurse aides to provide all care for the remaining 16 hours of the day.

OBRA 87 included in its Medicaid amendments provisions that eliminate the distinction between SNFs and ICFs. In their place, OBRA creates, effective Oct. 1, 1990, a new category of nursing home provider referred to as a nursing facility (NF). At that time, nursing facilities will have to meet a single set of requirements in order to participate in Medicaid. In general, these are almost identical to Medicare's requirements for facilities particpating in that program.

For licensed nursing staff, OBRA 87 requires that NFs meet Medicare requirements; that is, 24-hour licensed nursing care, with a registered professional nurse at least 8 consecutive hours a day, 7 days a week. However, OBRA provides a broader waiver authority for NFs than it does for Medicare SNFs. OBRA permits waivers for both the registered nurse and the licensed nurse requirements. In addition, States will provide the waivers, and not HCFA.

[8]Kimelblatt, Mary Howe. *The Nursing Shortage.* American Association of Retired Persons, The Public Policy Institute. Jan. 1989. p. 17.

legislation of 1987 anticipated this by requiring the Secretary of HHS to provide the States technical assistance for the development and implementation of case-mix reimbursement systems.

You may want to include in your bill a technical clarification of which nursing personnel would be required to be paid wages and benefits equivalent to those outside the nursing home. Your bill specifically states that they would include nursing personnel who provide or supervise direct care of nursing home residents and specifically mentions nurses' aides. You may also want to specify registered nurses and licensed practical and vocational nurses engaged in the required activities.

The National Nursing Home Survey

1985 Summary for the United States

Data collected in the 1985 National Nursing Home Survey are presented in 88 tables according to standard sets of descriptive variables. The tables are grouped into six categories: facility characteristics, registered nurse characteristics, current resident characteristics, resident characteristics by next of kin, discharge characteristics, and discharge characteristics by next of kin. Data are presented on utilization measures, available staff, cost of providing care, health and functional status of residents and discharges, and payment for care. Information usually not available from the nursing home on residents and discharges is available from the next of kin and is presented for the first time in this report. The 1985 National Nursing Home Survey covered all types of nursing homes in the conterminous United States.

Data From the National Health Survey
Series 13, No. 97

DHHS Publication No. (PHS) 89–1758

U.S. Department of Health and Human Services
Public Health Service
Centers for Disease Control
National Center for Health Statistics
Hyattsville, Md.
January 1989

Table 16. Percents and standard errors of employment factors related the retention of registered nurses in nursing homes by importance: United States, 1985

Retention factors	Importance of selected factors to retention											
	Not important		Slightly important		Some importance		Very important		All important		Unknown	
	Percent	Standard error	Percent	Standard error	Percent	Standard error	Percent	Standard error	Percent	Standard error	Percent	Standard error
Clinical supervision available:												
By a master's prepared clinical specialist	33.4	1.2	19.2	0.9	27.0	1.0	10.8	0.8	2.7	0.4	6.2	0.6
By experienced nursing home nurses	3.6	0.5	8.5	0.8	20.3	1.0	43.0	1.2	20.3	1.0	4.2	0.5
Career counseling	24.1	1.0	23.2	1.0	27.6	1.2	10.6	0.9	3.6	0.5	4.9	0.5
Job advancement possibility along clinical lines	4.9	0.6	7.1	0.6	20.3	0.9	42.9	1.2	21.0	1.0	3.8	0.5
Job advancement possibility along administrative lines	10.8	0.8	12.7	0.8	29.0	1.1	29.6	1.1	14.3	0.8	3.7	0.5
Ability to arrange work hours to work:												
During child's school hours	8.3	0.7	5.8	0.6	14.6	0.8	41.8	1.1	25.4	1.0	4.1	0.5
During child's school terms	12.0	0.8	9.9	0.7	19.2	1.0	35.1	1.1	19.4	0.9	4.3	0.5
During weekdays only	9.4	0.7	11.0	0.8	26.6	1.2	31.1	1.1	17.3	0.9	4.5	0.5
During weekends only	18.6	1.0	13.4	0.8	28.4	1.1	23.8	1.0	10.7	0.7	5.1	0.6
Rotating shifts	20.7	1.2	10.5	0.8	18.8	1.1	22.1	1.0	16.4	1.0	5.4	0.5
Day shift only	5.2	0.5	4.8	0.5	16.3	0.8	38.6	1.2	30.7	1.2	4.5	0.5
Evening shift only	13.9	0.8	7.7	0.6	23.7	1.0	30.3	1.1	19.2	1.0	5.2	0.5
Night shift only	16.7	0.9	8.0	0.6	21.5	1.0	29.4	1.1	19.0	1.0	5.4	0.5
Not required to "float" to unfamiliar units	9.1	0.7	7.8	0.7	17.9	0.9	32.0	1.1	28.5	1.4	4.7	0.5
Pay differential for:												
Evening shift	6.9	0.6	4.7	0.4	15.7	1.0	37.2	1.2	31.5	1.4	3.9	0.5
Night shift	6.3	0.6	4.0	0.4	14.4	0.9	36.0	1.2	35.1	1.4	4.2	0.5
weekend work	7.5	0.6	4.8	0.4	17.2	0.9	35.0	1.1	31.4	1.2	4.1	0.5
Holiday work	3.7	0.4	3.1	0.4	12.0	0.8	36.6	1.1	41.2	1.2	3.4	0.4
Pay differential or separate salary scale by educational preparation	8.7	0.8	9.8	0.7	25.0	1.1	31.7	1.2	21.0	1.0	3.8	0.4
Graduated salary plan with increases according to:												
Length-of-service	1.6	0.3	2.4	0.4	9.3	0.7	39.7	1.3	43.7	1.3	3.3	0.4
Merit	2.6	0.4	2.7	0.4	10.6	0.8	37.1	1.2	42.7	1.3	4.3	0.5
Graduated vacation plan varying according to length-of-service	0.8	0.2	2.2	0.4	8.8	0.7	41.7	1.2	43.0	1.3	3.6	0.4
Leave of absence for maternity	9.9	0.7	5.8	0.6	18.1	0.9	34.7	1.2	27.1	1.1	4.4	0.5
Child care facilities	21.6	1.0	12.9	0.9	26.2	1.0	21.1	1.1	13.1	0.8	5.1	0.5
Free parking	14.4	0.8	8.2	0.6	17.6	0.9	29.0	1.0	26.8	1.1	4.0	0.5
Convenient public transportation	29.2	1.1	10.9	0.7	23.4	1.1	21.6	1.0	15.4	1.0	4.5	0.5
Meal at no cost or subsidized	20.6	1.0	14.1	0.8	28.5	1.2	19.0	0.9	13.6	1.0	4.3	0.5
Subsidized housing	52.9	1.3	14.2	0.9	17.7	0.9	5.5	0.6	4.1	0.5	5.5	0.5
Laundry of uniforms	54.0	1.4	13.7	0.8	16.6	0.9	5.3	0.5	4.6	0.6	5.8	0.5
Insurance plans at no cost or partially paid for covering:												
Hospitalization	2.8	0.4	1.1	0.2	5.7	0.5	34.6	1.2	52.7	1.4	3.1	0.4
Medical or surgical care	3.2	0.4	1.2	0.2	6.7	0.6	34.5	1.2	51.1	1.4	3.3	0.4
Dental	4.7	0.5	3.9	0.4	15.4	0.9	33.5	1.1	38.6	1.4	3.8	0.4
Life	8.7	0.8	7.9	0.7	18.6	1.0	29.9	1.1	31.3	1.2	3.7	0.4
Retirement plan (other than Federal social security) partially or totally paid for by employer	3.2	0.4	3.8	0.5	19.5	0.9	33.3	1.0	40.4	1.1	3.8	0.4
Availability of physicians	5.0	0.7	5.1	0.5	16.0	0.9	37.6	1.2	31.7	1.1	4.0	0.5
Availability of support service personnel and professionals to do nonnursing tasks	2.3	0.5	3.6	0.4	16.3	0.9	39.4	1.2	34.7	1.1	3.7	0.5
Well-equipped facility with functional nursing units	0.7	0.2	1.0	0.3	6.0	0.6	36.4	1.1	52.3	1.2	3.6	0.5
Security personnel available	9.0	0.7	11.0	0.8	27.9	1.1	27.8	1.2	20.0	1.0	4.0	0.5
Use of facility as clinical center for nursing students	27.1	1.1	13.9	0.8	33.9	1.1	14.0	0.9	6.7	0.6	4.3	0.5
Opportunity for professional development such as participation in clinical nursing conferences and nursing research projects	8.1	0.7	9.5	0.7	31.1	1.2	30.6	1.2	16.7	0.9	4.0	0.5
Availability of college tuition reimbursement plan	10.6	0.7	11.1	0.8	24.4	1.1	29.8	1.1	19.7	1.0	4.3	0.5
Release time with pay for continuing education	0.8	0.2	0.2	0.7	21.4	1.1	35.4	1.2	24.2	1.1	4.0	0.5
Reimbursement for expenses for continuing education	5.1	0.5	5.9	0.6	19.6	1.0	39.1	1.2	26.5	1.1	3.9	0.5
Provision of in-service education	1.7	0.3	3.4	0.4	14.4	0.9	42.4	1.3	34.7	1.1	3.4	0.4
Provision of comprehensive orientation program for those newly hired	2.9	0.4	3.0	0.3	12.5	0.8	33.0	1.0	45.2	1.2	3.4	0.4

SOURCE: Bureau of Health Professions, O. G. Jones, A. J. Bonito, S. G. Gamer, and R. L. Williams. 1987. Analysis of the environment for the recruitment and retention of registered nurses in nursing homes. Public Health Service. Washington: U.S. Government Printing Office.

Mr. WALGREN. Mr. Chairman, this Nation is on a collision course as the population ages and budgets shrink. What we as a Nation have to face up to is whether we are going to devote to our health care system the resources required.

People expect nursing homes to provide nursing care. Government must help assure that nursing home care is the quality that we each would expect for our patients, ourselves or any member of our family.

Mr. Chairman, I want to express again my appreciation for the focus that you give of your subcommittee to this particular issue, and express my appreciation for being able to join you and hear the testimony that is presented.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Walgren.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. Chairman, as a cosponsor of this bill I take this opportunity to express my strong support of it. H.R. 1649, as we know, would require Medicaid to pay nursing home staffs wages and benefits that are comparable to other health facilities.

One of the prime reasons I support this legislation is because I represent an area with a very large elderly population. As a matter of fact, my mother is in a nursing home now. She has been in and out of the hospital the last few months between nursing homes and the hospital. So there are a significant number of nursing homes within my district and throughout the entire State of Florida.

I would like to take this opportunity to thank and commend Chairman Walgren. He and I introduced legislation previously regarding the need to better staff registered nurses in the nursing homes. That legislation hasn't been moving, but it is something I think we have got to take another look at.

In order to ensure a higher quality of care, I believe the persons who reside in nursing facilities are entitled to the same kind of care. While I want to make it clear that nursing homes do have stringent operating procedures, certain factors beyond the administration's control can be harmful to the quality of health care received in certain facilities.

The major problem, of course, is, as Chairman Walgren indicated, is the low pay of nursing personnel. Salaries paid to registered nurses employed by nursing homes are approximately 35 percent lower than the salaries of registered nurses who work in hospitals. There are pay discrepancies as well, for other nursing staffs including LPN's and nurse aides.

My question is, and of course, the question from all of us, I suppose, is, should a nurse be penalized—which she is—for choosing to work in a nursing home instead of a hospital?

In my opinion, this pay difference harms the morale of the nurses employed by the nursing facilities. It also hinders recruiting efforts, as has been said earlier.

Nursing homes are not always able to attract the best candidate for the job. Who does this hurt in the long run? Of course, it is the patient. I believe the best way to resolve this problem is to set up a nursing home pay scale for nurses that is comparable to other health care facilities.

I am concerned about the amount of money this legislation could cost State Medicaid programs. We have to look at that, and I hope our witnesses today will be able to shed some light on this particular problem.

But I am convinced, Mr. Chairman, as I know you are, that something must be done to rectify this pay in equity, and I look forward to discussing this legislation today.

Mr. WAXMAN. Thank you very much.

Dr. Rowland.

Mr. ROWLAND. Thank you very much, Mr. Chairman, and I commend you for this hearing and our colleague Doug Walgren for introducing this legislation.

As one who has worked in nursing homes over the years as a physician, I am acutely and personally aware of the constant struggle that goes on the quandary that is faced in providing quality care for patients in nursing homes, and I believe it is only through the dedication and commitment of RN's and LPN's and nurse aides that the quality of care is maintained.

So I think it is so very important that attention be focused on this area, and that a commitment be made to see that those people who are so dedicated and committed are compensated adequately for their dedication and commitment, and I do appreciate this hearing very much, Mr. Chairman.

Mr. WAXMAN. Thank you, Dr. Rowland.

Mr. Whittaker.

Mr. WHITTAKER. Thank you, Mr. Chairman. I want to thank you for holding this hearing on this very important issue. I also want to thank our colleague and personal friend Doug Walgren from Pennsylvania for introducing this bill and bringing us to this point.

Doug and I have had some interesting conversations through the years. I have long been a strong supporter of providing educational assistance in an effort to increase the supply of nurses, as well as areas that could possibly increase the manpower or the woman power, if it would, and thus, the availability of nurses.

I have some concerns about this bill that I would be remiss if I didn't mention, and I discussed these with Mr. Walgren on related issues. I represent a rural constituency, and I am very troubled when we mandate certain provisions to be implemented across the board, be it in the levels of nursing care and/or wages to be paid as this bill would do.

It is my concern that it does not, as an unintended effect, end up closing nursing homes and then causing my constituents to either have to transfer their residency into a metropolitan area where the beds may then be available or the families to transfer that elderly loved one who now is able to reside in a reasonable proximity to their family and loved ones, into a metropolitan area.

I also have some concerns about how the prevailing or the regional wage determination might be implemented administratively. We have heard a number of horror stories which occur in rural areas, where through the experience of the prevailing wage requirement under some of the Federal contracting statutes, many areas in my district end up paying as much as 30 and 40 percent more for projects than it would cost to actually construct them, because the regional prevailing wage base has been determined to be

so wide that they end up having to pay the prevailing wage of areas that are in some cases over 120 miles away from them.

And as a classic example, as we have had occur where a community is trying to build a new fire station, and they ended up having to build two thirds the size instead of the full size, simply because they had to pay a premium on wages that didn't have to be paid in order to do the construction.

Now, that is not, I know, a direct correlation, but it is one I am concerned about how these prevailing or these regional wage rates will be determined.

I look forward to the hearing. I am going to be listening to the witnesses, and I hope we can come up with something, but I do want some awareness shed on the challenges of the rural area.

Again, when you mandate levels of service and wages that are beyond the prevailing existing structure in those rural areas, sometimes the unintended effect is to actually force those nursing homes into bankruptcy and closure, and then no one is served.

Thank you.

Mr. WAXMAN. Thank you very much, Mr. Whittaker.

Without objection, the record will stay open for other members who wish to insert opening statements.

Our first two witnesses have long been involved with benefit parity for nursing home personnel and with the even broader question of nursing home quality of care.

Dr. Charlene Harrington is professor and vice chair of the Department of Social and Behavioral Sciences at the School of Nursing at the University of California in San Francisco. She also serves as associate director of the school's Institute for Health and Aging.

Ms. Sarah Burger is a registered nurse who is currently working with an organization that represents nursing home residents, the National Citizens' Coalition for Nursing Home Reform. Ms. Burger is testifying today on behalf of that group.

I want to thank both of you for coming to our hearing this morning. Your complete testimony will be in the record in full. We would like you to limit your oral testimony to no more than 5 minutes. We have to be very strict about the 5-minute rule for all witnesses in order to complete the schedule of this hearing.

Dr. Harrington, why don't we start with you.

STATEMENTS OF CHARLENE HARRINGTON, ASSOCIATE DIRECTOR, INSTITUTE FOR HEALTH AND AGING, SCHOOL OF NURSING, UNIVERSITY OF CALIFORNIA; AND SARAH BURGER, ON BEHALF OF THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Ms. HARRINGTON. Good morning. Thank you very much for the invitation to be here. I am very pleased to be here to support this legislation.

Wages and benefits for nursing personnel in nursing homes are scandalously low. As was mentioned earlier, staff nurses make 22 percent below the comparable wages that nurses in hospitals make. Nurse administrators in nursing homes make 45 percent less than nurses in hospitals.

These low salaries are also found for licensed practical nurses and nursing assistants. Nursing assistants work for minimum wages and many have no benefits at all.

There are a number of serious consequences for these low wages and benefits to nursing homes. The most important consequence is low staffing levels in nursing homes.

Nursing homes have only one register nurse for every 20 patients on average and registered nurses only spend 6 to 12 minutes for each patient every day.

The shortage of nurses is growing nationally and it is even worse in nursing homes because they are not competitive with hospitals. And this is going to continue to be the case unless the wages are made to be at the same level.

About 60 percent of the nursing homes have one or more vacancies for registered nurses and 32 percent do not even meet the minimum staffing standards because they have vacancies which they are not able to fill. The prime reason is the low wages and benefits.

This also results in high turnover rates, which can be as high as 55 to 100 percent a year. I have even heard of nursing homes with 300 percent turnover rates.

Another consequence is that nurses in nursing homes have substantially lower educational levels than nurses in hospitals. The high turnover rates, the lower education level, the shortages all lead to disastrous consequences in terms of quality of care for those people who are sick and disabled in nursing homes.

We know that over one third of the Nation's nursing homes are operating at a substandard level with poor nursing care, problems of abuse, unsanitary conditions, poor food and many other problems. We also know from the research that low staffing levels are directly related to poor outcomes in nursing homes. Studies have shown that high catheter use, poor skin care, functional decline and death are all related to poor staffing and high turnover rates.

Other studies have shown the very positive benefits of having nurse practitioners and nursing specialists in nursing homes.

The higher staffing levels could not only improve quality but we must not forget, that they can also save money. One recent study of nursing home residents found that 48 percent of all the hospitalizations from nursing homes could have been prevented—at a savings of an estimated $0.9 billion within 1 year—if we had had more highly trained nurses within nursing homes.

Now Government faces a real dilemma because we know of the deficit problems and nursing home costs are increasing very rapidly. The estimate is they are going to increase by 11 percent between 1989 and 1990, to almost $55 billion. Medicaid, of course, is paying almost half of this bill, so this is a problem for Government.

On the other hand, if we are going to make fundamental reform in nursing home quality, we must do something about the wages and benefits. And we know this is extremely important because nursing home care is becoming more complex. There is a tremendous increase in the complexity of care because of the age of the nursing home residents and their increased disability levels over the last 3 to 5 years. And as this complexity increases, we have a need for better nursing personnel.

This bill would provide parity wages and benefits that are really crucial. I want to stress the benefits because some nursing home personnel do not even have health care benefits. Therefore, these people are among the 37 million uninsured in the United States. This ultimately results in higher costs to the Medicaid program when these individuals face catastrophic illness and have no other recourse for health care.

This legislation needs to have strong provisions for nursing home accountability for any new funds. In two instances in California, when the State allocated additional funds for nursing personnel in nursing homes, these funds were not fully allocated to the personnel. We need to have strict penalties instituted.

In summary, I just want to say I very strongly support this legislation and think it will have wonderful benefits for nursing homes.

Mr. WAXMAN. Thank you very much, Dr. Harrington.

[Testimony resumes on p. 47.]

[The prepared statement of Ms. Harrington follows:]

WAGES AND BENEFITS OF NURSING PERSONNEL IN NURSING HOMES: CORRECTING THE INEQUITIES

Wages and benefits for nursing personnel in nursing homes are scandalously low. Nursing home salaries for registered nurses are 15-45 percent below the levels for comparable positions in hospitals. 1,2 Staff nurses in nursing homes have salaries 22% below comparable nurses in hospitals, while registered nurses working as administrators in nursing homes are earning 45 percent less than nursing working in hospital administration. 2 These salary differentials are also found for licensed practical nurses, nursing assistants, and other nursing personnel. Nursing assistants, who make up the majority of all nursing home direct care personnel, generally work for minimum wages and some have no benefits, including health insurance.

There are a number of serious negative consequences to low wages and benefits for nursing personnel in nursing homes in terms of quality of care and hospitalization costs. This paper argues that improvement in the wages and benefits are fundamental to reform of nursing home quality. If federal policy changes are not made to address the situation, nursing home quality will grow worse as the demand for nursing home care increases, the complexity of nursing home care increases, and the supply for nursing home beds is constrained. Government faces a serious policy dilemma because it needs to balance the costs of the Medicaid program with the need to ensure a minimum level of quality in nursing homes.

A legislative proposal, H.R. 1649, which would require Medicaid to pay wages in nursing homes that are comparable to those paid to other health personnel in each locality, is one approach to address the problem. Such a change would require substantial new federal funds which can be phased in over a period of time, and would require provisions to ensure nursing home accountability for such additional funds.

DIRECT CONSEQUENCES OF INADEQUATE WAGES AND BENEFITS

The direct consequences of inadequate wages and benefits for nursing personnel in nursing home are: inadequate staffing levels, high staff turnover rates, lower educational levels

of staff, poor quality of care, and higher costs.

Inadequate Staffing Levels and Labor Shortages. The most important direct consequence of inadequate wages and benefits is the low staffing levels in nursing homes. There are only 5.1 FTE RNs per 100 patients in nursing homes, in contrast with a ratio of 1 RN for every 4.5 patients in hospitals. 3 There are 7.4 LPNs (FTE) per 100 and 30.8 nursing attendants (FTE) per 100 patients in nursing homes. 3 Current attendant ratios are sometimes 1 for every 15 patients during the day, 1:25 in the evening, and 1:40-50 at night. 1

The shortage of registered nurses in nursing homes is growing as the an overall shortage of registered nurses continues nationally. The shortage is greater in nursing homes than hospitals because of the lower wages and benefits paid to nursing personnel. One survey indicated that about 60 percent of nursing homes had one or more vacancies for both registered nurses and licensed practical nurses. 4 One-third indicated a need for one or more RNs just to meet current minimum staffing standards. 4 As competition for nurses increases with higher wages, benefits, and bonuses paid by hospitals, nursing homes will increasingly be a disadvantage in attracting nurses.

The inadequate numbers of nurses within nursing homes result in registered nurses spending little time with nursing home residents in direct care. In one study, RNs in hospitals spent an average of 45 minutes per patient per day compared to less than 12 minutes for RNs in nursing homes. 5 Nearly 40 percent of the 7,402 nursing homes in the survey reported 6 minutes or less of RN time per patient per day. 5

High Staff Turnover Rates. Low wages and benefits are directly reflected in the high turnover rates for nursing home personnel. The overall nursing personnel turnover rates in nursing homes are frequently as high as 55-100 percent per year. 1 A number of studies have identified poor working conditions combined with heavy resident workloads, inadequate training and orientation, and few opportunities for advancement as other factors which contribute to high turnover rates in some facilities. 6 This problem is exacerbated by low ceilings on maximum wages nurses can earn. Many nurses reach their maximum earnings within a few years of

employment, so that they have no incentive to continue long term employment. High turnover rates are considered undesirable in terms of quality outcomes, and yet some nursing homes encourage high turnover rates to keep wages low, particularly in proprietary facilities. 5

Lower Levels of Education and Specialty Training. Low wages and benefits for nursing home personnel result in registered nurses with substantially less education in nursing homes than hospital nurses. Fifty-six percent of all RNs working in nursing homes are diploma prepared nurses and less than 3% had their master's degree. 3 Many nursing homes are unwilling to pay the higher wages required to attract better prepared nurses, and yet evidence suggests that higher education levels are related to higher quality of care.

Several geriatric nurse practitioner (GNP) and teaching nursing home demonstration projects have demonstrated the positive relationship between the education and training of nurses and high quality of care. One study, which compared 30 nursing homes employing GNPs with 30 matched control homes, found that the use of GNPs resulted in favorable changes for residents in two out of eight activity of daily living measures; five of 18 nursing therapies; two of six drug therapies; and six of eight tracers. 7 The study also reported some reduction in hospital admissions and total days in those facilities using GNPs. 7

Preliminary results from the Robert Wood Johnson Teaching Nursing homes confirm the benefits of highly trained nurses for improving both the process of care and the outcomes of care. 8 One study found the presence of masters prepared nurses resulted in decreases in decubiti, use of physical restraints, catheters, incontinence, dependency, psychotropic drugs, enemas and laxatives. 9 Another study reported a gradual decline in emergency room visits, hospital admissions, infections and falls. 10 Another reported a decrease in pharmacologic agents and nosocomial infections from the use of clinical nursing specialists. 11

Problems With Quality of Care. The poor quality of care provided in U.S. nursing homes has long been a matter of concern to consumers, professionals, and policy-makers. Recently, the General Accounting Office reported that over one-third of the nation's nursing homes are operating at a substandard level, below minimum federal standards during three

consecutive inspections. 12 Among the findings were evidence of untrained staff, inadequate provision of health care, unsanitary conditions, poor food, unenforced safety regulations, and many other problems. 12,13 No other segment of the health care industry has been documented to have such poor quality of care. Despite a large infusion of public funds into the nursing home industry over the past twenty-five years, investigations and exposes continue to find inadequate care and patient abuse. 12

In 1986, the Institute of Medicine's Study on Nursing Home Regulation reported widespread quality of care problems and recommended the strengthening of federal regulations for nursing homes. 13 These recommendations, as well as the active efforts of many consumer advocacy and professional organizations, resulted in Congress passing a major reform of nursing home regulation in 1987, the first significant changes since Medicare and Medicaid were adopted in 1965. 14 Congress has made enhanced regulatory efforts a priority in spite of the costs associated with regulation in an effort to improve quality of care and to protect residents from abuse.

Regulatory efforts, while essential, are not sufficient to improve the overall quality of nursing home care. Rather, efforts to resolve the nursing home labor problems, primarily by improving wages and benefits, are essential if nursing home care is to be safe, to ensure high quality of care, to preserve basic resident's rights, and to promote quality of life for residents.

Research has demonstrated that higher staffing levels in nursing homes are associated with higher quality of nursing care. Spector and Takada, in a recent study of 2,500 nursing home residents in 80 nursing homes in Rhode Island, found that low levels of staffing in homes with very dependent residents were associated with reduced likelihood of resident improvement. 15 High catheter use, a low percent of residents receiving skin care, and low participation rates in organized activities were also associated with reduced outcomes, in terms of functional decline and death. 15

Higher Costs of Care. Higher staffing levels could not only improve quality, but could also reduce the cost of hospitalization. A recent study of nursing home residents found that 48

percent of hospitalizations could have been avoided. Factors such as an insufficient number of adequately trained nursing staff, the inability of nursing staff to administer and monitor intravenous therapy, lack of diagnostic services, and pressure for transfer from the staff and family were found to contribute to unnecessary hospitalization. 16 The investigators estimated that 216,000 of the nursing home residents who are hospitalized annually might be treated in nursing homes, for a cost savings of $.9 billion in the United States. 16

THE NURSING HOME MARKET THREATENS GREATER QUALITY PROBLEMS

Three factors in the nursing home market threaten to increase labor market problems for nursing homes, with serious effects on consumers.

Increased Demand for Nursing Homes. The demand for nursing home services is growing with the increasing numbers of individuals who are aged and chronically ill. In 1987, there were about 30 million Americans who were age 65 and older and this number is projected to increase to 51 million in 2020. 17 As the population ages and develops chronic illnesses, the demand for long term care services including nursing home services increases.

The adoption of prospective payment systems for hospitals by Medicare in 1983 has resulted in shortened hospital stays and increases in the demand for nursing home care. This policy change has resulted in increased numbers of referrals and admissions to nursing homes from hospitals, as well as increased acuity levels of residents in nursing homes. 18 At the same time, the new 1988 Health Care Financing Administration (HCFA) Medicare guidelines to the fiscal intermediaries liberalized Medicare coverage for nursing homes. 19 These changes encourage the demand for and use of nursing home and other long term care services, and consequently the need for more nursing personnel in nursing homes.

Increased Complexity of Care. The demand for increasingly more complex services in nursing homes is growing with the aging and disability of the residents. While only 4 percent of the nation's elderly are currently in nursing homes, 88 percent of nursing home residents are aged 65 and older. 20 The population in nursing homes is aging so that the median age is 82. 20 The

proportion of residents who were 85 years and older rose from 30 to 40 percent between 1976 and 1985. 20

The disability levels of nursing home residents is increasing. Between 1976 and 1984, the number of residents who were totally bedfast rose from about 21 to 35 percent of the discharges and the number dependent in mobility and continence increased from 35 to 45 percent. 21 The average resident has about four out of six limitations in activities of daily living, and 66 percent have some type of mental impairment or disorder. 20

As the acuity level of nursing home residents increases, medical technology formerly used only in hospitals is now being used in nursing homes. Thus, the "performance of duties" has become an even more complex task for personnel. The use of intravenous feedings and medication, ventilators, oxygen, special prosthetic equipment and devices, and other high technologies has made patient care management more difficult and challenging. 22,23 The appropriate use of technology, the training and skill levels needed by nursing home personnel, and the need for emergency back-up procedures have all become problems which derive from the use of high technology. Thus, the growing complexity of needs of nursing home residents require additional nursing personnel with greater skills levels and educational training.

Constrained Supply. While the demand for increasingly complex nursing home care is growing, the supply of nursing home beds has not kept pace with demand. In 1985, there were approximately 19,100 facilities providing care for 1.5 million residents, including hospital-based facilities and residential facilities. 20 About 75% of these nursing homes are certified to provide services to the Medicare and Medicaid program. During the 1980s, the growth in beds slowed below the rate of growth of the aged population. 24 As the supply of beds has been constrained (except in the southwest), the average occupancy rate has increased to 92% nationally. 20 The slowing of growth in new nursing homes is the result of complex market factors including the high costs of capital construction, shortages in the labor market, recent lowering of profit-rates over previous high levels, and in some states, limits on construction by state regulations. 25

This limited supply and the high demand for services has created a situation where

nursing homes are able to select the residents they admit. Because they can obtain private-paying residents who can be charged higher daily rates than publicly-paid residents, nursing homes prefer private clients and frequently discriminate against those who are on Medicaid. 26 Some nursing homes attempt to "cream" or select those patients that are the least sick or for whom they can provide the most cost efficient care. This, in some situations, reduces access to those individuals with the greatest need and certainly limits consumer choice and the competitive market for services.

POLICY DILEMMAS FOR GOVERNMENT

Government faces the difficult problem of rapidly increasing costs for nursing home and other health services. The nation spent $49 billion on nursing home services in 1989 (8 percent of its total health dollar) and expects to spend $54.5 billion in 1990, making this segment of the health industry third only to hospitals and physicians. 27 While the growth in nursing home rates has slowed somewhat, the increase in 1989 was 11.2 percent over the previous year, well beyond the 5 percent rate of inflation. 27

The growing costs of nursing home care have negative consequences for public payers, primarily Medicaid. Of the total amount spent, almost one-half of the revenues come from Medicaid. Medicare pays for less than two percent of the public dollars and Medicaid (for those with low incomes) pays most of the remainder.

Because of the overall cost increases in health care, most public policy efforts at both the federal and state levels are focused on controlling or reducing Medicaid and Medicare spending. The federal governments has reduced payments to states for the Medicaid program systematically since the 1980s. 25,28 States have in turn made a number of policy changes to reduce Medicaid payments to nursing homes. 29 These policy changes have been effective in constraining Medicaid expenditures for nursing homes, but these controls have had serious negative consequences for consumers and for nursing home personnel. Government must struggle to balance its interests in ensuring minimum levels of quality while at the same time controlling costs and operating under severe fiscal constraints.

Effects of Medicaid Cost Containment on Consumers. Individuals and their families must pay about one-half of the nation's nursing home expenses directly out-of-pocket, because private insurance and Medicare pays for so little care (about 3% of the total costs in 1988). 2 Most individuals who require nursing home services for any extended period of time are forced to spend their life savings before they become poor enough to qualify for Medicaid services which will then pay for such care. The average annual costs of $29,000 in 1987 results in many individuals spending their assets within weeks of admission to a nursing home. 30 The high costs of nursing home care not only result in impoverishment but also in inequities in access, with the greatest access for those with the greatest income and limited access for the poor. As Medicaid reduces expenditures for nursing homes, this shifts increasingly higher financial burdens on the aged and disabled who are the least able to pay for such services.

Effects of Medicaid Controls on Nursing Home Personnel. Since Medicaid pays almost half of the total nursing home expenses, Medicaid policies have a critical impact on nursing homes. As Medicaid controls reimbursement levels, nursing homes have responded primarily by limiting wages and benefits for nursing personnel. The poor wages and benefits for nursing personnel, which have led the problems of poor quality, are directly related to Medicaid reimbursement and fiscal policies.

Effects of Medicaid Cost Containment on Providers. While Medicaid cost controls on reimbursement rates have had negative on nursing personnel, most nursing homes continue to do well financially. Nursing homes used government funds, particularly after the introduction of Medicaid in the 1960s and 1970s, to build and develop a large for-profit nursing home industry. The nursing home industry, with the exception of the drug industry, has more proprietary ownership and chain ownership than any other segment of the health industry. In 1985, 75 percent of all nursing homes were profit making, 20 percent were nonprofit, and 5 were government. 20

A growing number of nursing homes are chain-owned or operated, and they have increased their control of the total market dramatically. In 1973, the three largest chains owned

2.2 percent of the beds, (31) but by 1985, chains owned 41 percent of the total facilities and 49 percent of the nation's nursing home beds. 20 Many of the US for-profit health care chain corporations have become multinational, owning companies in other countries. 27

Nursing home corporations have traditionally been very profitable especially in the late 1970s and early 1980s. 31 While some chains experienced losses since 1987, other nursing home chains such as Manor Care and National Medical Enterprises continued to be profitable with 14-17 percent returns on equity in 1989 over the previous year and 13-22 percent earnings per share for the past 10 year period. 32 Some profit-making nursing homes have been creative in using administrative expenses to further enhance the income of owners. Complex lease-back arrangements, creative financing mechanisms, real estate speculation, and buying and selling among interested parties make nursing home economics one of the most difficult areas within the health industry to understand. 33

Nonprofit nursing home corporations are also increasingly responding to the competitive economic environment by placing great emphasis on the enhancement of net revenues. The distinctions between profit and nonprofit corporate ownership are increasingly blurred as both types of corporations become part of multiorganizational systems. The quality of care outcomes and performance measures for both nonprofit and proprietary nursing homes are difficult to differentiate, although proprietary facilities are generally considered to have more quality problems. 5, 31

The desire to enhance profits and net revenues encourages nursing homes to reduce expenditures for needed nursing personnel, particularly by keeping wages and benefits artificially low. Since nursing home personnel are primarily unskilled and generally not unionized, they have little leverage in increasing wages and benefits. Where facilities tend to pay poor wages and benefits, have high turnover, have less educated staff, it is not surprising that there is a relationship with poor quality of care.

PUBLIC POLICY APPROACHES

In the past, government has been unwilling to regulate the high profits and administrative

costs and the low staff wages and benefits within nursing homes, as it has traditionally been reluctant to intervene in the private health industry. Although government must control its expenditures on nursing homes, it should not continue to allow the inadequate wages and benefits for nursing personnel in nursing homes. The consequences of inadequate wages/ benefits on poor quality of care for residents, high hospital costs, and on nursing home personnel themselves are great.

Parity wages. Parity wages should be required for nursing homes personnel with other health personnel as is proposed by H.R. 1649, sponsored by Hon. Doug Walgren. This legislation would require each state Medicaid plan to provide parity wages for all nursing personnel in nursing homes with those in other health care settings in each locality. For the purposes of determining wage rates of nonnursing home personnel in a locality, the bill would require states to conduct a survey of statistically representative samples of facilities within local areas. Because the bill would result in additional costs to Medicaid, the bill is wisely proposed to be phased in over a six year period.

Parity Benefits. While parity wages within localities are proposed in this legislation, parity in benefits which are not proposed, are equally important. Some nursing personnel in nursing homes do not have health benefits. Thus, they are among the 37 million uninsured individuals in the United States, of whom 75 percent are employed by businesses who do not offer health benefits to their employees. 34 Failure by government to require health benefits for nursing home personnel ultimately results in greater numbers of individuals relying on Medicaid for health benefits, and consequently increasing the overall costs of government. Nursing home employers should be mandated to provide health benefits to all employees regardless of their fulltime or parttime status.

Public Accountability for Nursing Home Expenditures.

Because substantial amounts of public funds to nursing homes have been traditionally used to finance excessive administrative costs, high profit rates, and the expansion of chain operations, there is a legitimate distrust of the industry by government and an reluctance to spend

more government money. In the past, nursing homes have not always used public funds in responsible ways. In two instances in California, when the state allocated additional funds for nursing personnel in nursing homes, these funds were not fully allocated to nursing personnel. Some nursing homes only partially passed on the funds to their personnel, while 20 percent of facilities made no wage pass-throughs to nursing personnel. 35

If Medicaid wages and benefits are increased for nursing personnel in nursing homes, government must develop methods to make nursing homes financially accountable. Nursing homes which fail to meet minimum salary and benefit provisions should not only be required to return government funds (as proposed in H.R. 1649), they should be subject to financial penalties and an annual financial audit by government. Revenues and expenses for nursing personnel in nursing homes should be required to be accounted for separately from funds for administration, profits and capital costs, so that financial accountability can be assured by public payers. Finally, and most important, maximum limits for expenditures should be placed on nursing home administrative costs, profits, and capital expenditures on all nursing homes participating in the Medicaid and Medicare program. These provisions would ensure that nursing homes place primary emphasis on high quality nursing personnel and high quality of care, rather than on profits and growth.

SUMMARY

The nursing home industry is growing in size and importance as a provider of long term care. The major problems with the nursing home industry in terms of quality, access, and quality are likely to grow in magnitude as the demand increases and the supply is relatively inelastic. Highest priorities should be placed on supporting regulatory efforts to improve quality of care.

Regulation alone will not improve nursing homes. Nursing home care is entirely dependent upon the quality of nursing personnel that provide services in the facilities. In order to improve quality, reduce hospitalization costs, and provide humane care, the government must ensure that nursing homes provide equitable wages and benefits to its employees to attract the type of high quality personnel that we would all want to be providing care to our parents or to

ourselves if we were sick and in a nursing home. This effort will cost substantially more in terms of public funds but is essential to the improvement of nursing homes in the United States.

REFERENCES

1. Harrington, C. Nursing home reform: Addressing critical staffing issues. Nursing Outlook, 35(5): 208-9, 1987.

2. U.S. Division of Nursing, Department of Health and Human Services (1988). 1988 National Sample Survey of Registered Nurses. Unpublished Data. Washington, DC: Division of Nursing.

3. National Center for Health Statistics, Strahan, G. (1988). Characteristics of registered nurses in nursing homes: Preliminary data from the 1985 national nursing home survey. Advanced Data from Vital and Health Statistics. No 152. PHHS Pub. No (PHS) 88-1250. Hyattsville, MD: Public Health Service.

4. American Health Care Association (1988). Manpower Survey 1987. Preliminary Draft Report. Washington, DC: American Health Care Association.

5. Jones, D., Bonito, A., Gower, S., Williams, R.. Analysis of the environment for the recruitment and retention of registered nurses in nursing homes. Washington, D.C.: U.S. Department of Health and Human Services, 1987.

6. Wagnild, G. (1988). A descriptive study of nurses's aide turnover in long term care facilities. Journal of Long-Term Care Administration, 19-23.

7. Kane. R., Garrard, J., Skay, C., Radosevich, D., Buchanan, J., McDermott, S., Arnold, S., Kepferle, L. Effects of a geriatric nurse practitioner on process and outcome of nursing home care. American Journal of Public Health. 79 (9): 1271-1277, 1989.

8. Mezey, M., Lynaugh, J. and Cartier, M. Reordering Values: The Teaching Nursing Home Program. Nursing Homes and Nursing Care: Lessons from the Teaching Nursing Homes. New York: Springer Pub. Co., 1-12, 1989.

9. Joel, L. and Johnson, J. Rutgers-the state university of New Jersey and Bergen Pines County Hospital. In Small, N. and Walsh, M. (eds), Teaching Nursing Homes, the Nursing Perspective. Owings Mill, MD: National Health Publishers, 1988.

10. Dimond, M. Johnson, M. and Hull, D. The teaching nursing home experiences, University of Utah College of Nursing and Hillhaven Convalescent Center. In Small, N. and Walsh, M. (eds), Teaching Nursing Homes, the Nursing Perspective. Owings Mill, MD: National Health Publishers, 1988.

11. Wykle, M. and Kaufmann, M. The teaching nursing home experiences, Case Western Reserve University, Frances Payne Bolton School of Nursing and Margaret Wagner House of the Benjamin Rose Institute. In Small, N. and Walsh, M. (eds), Teaching Nursing Homes, the Nursing Perspective. Owings Mill, MD: National Health Publishing, 1988.

12. U.S. General Accounting Office (GAO). Report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives. Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed. Washington, DC:

U.S. GAO, 1987.

13. Institute of Medicine (IOM), Staff and National Research Council Staff. Improving the Quality of Care in Nursing Homes. Washington, DC, National Academy Press, 1986.

14. Omnibus Budget Reconciliation Act of 1987 (OBRA, 1987). Public Law 100-203. Subtitle C: Nursing Home Reform. Signed by President, Washington, D.C., December 22, 1987.

15. Spector, W.D. and Takada, H.A. Characteristics of Nursing Homes That Affect Resident Outcomes. Paper Presented at the Gerontological Society of America, Annual Meeting, Minneapolis, MN., 1989.

16. Kayser-Jones, J., Wiener, C., Barbaccia, J. Factors contributing to the hospitalization of nursing home residents. The Gerontologist, 29 (4): 502-510, 1989.

17. U.S. General Accounting Office (GAO). Report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives. Long-Term Care for the Elderly: Issues of Need, Access, and Cost. Washington, DC: U.S. GAO, HRD-89-4, November 1988a.

18. Guterman, S., Eggers, P., Riley, G., Greene, T., and Terrell, S. The First 3 Years of Medicare Prospective Payment: An Overview. Health Care Financing Review, 9(3): 67-77, 1988.

19. Scanlon, W. Delivery of Long-term Care Services: Latest Developments in Nursing Homes and Housing. Commissioned Paper for The Economics and Politics of Long-Term Care, Sponsored By the University of California, Irvine and the FHP Foundation, p.5, October, 1989.

20. National Center for Health Statistics, Hing, E., Sekscenski, E., and Strahan, G.. National Nursing Home Survey: 1985 Summary for the United States. Vital and Health Statistics, Series 13, No. 97. DHHS Publication No. (PHS) 89-1758. Public Health Service. Washington, DC: U.S. Government Printing Office, 1989.

21. National Center for Health Statistics, Sekscenski, E. Discharges from Nursing Homes: Preliminary Data from the 1985 National Nursing Home Survey. Advance Data from Vital and Health Statistics, No. 142. DHHS Pub. No. (PHS) 87-1250, Hyattsville, MD: Public Health Service, 1987.

22. Harrington, C. and Estes, C.L. Trends in Nursing Homes in the Post Medicare Prospective Payment Period. San Francisco, CA: Institute for Health & Aging, 1989.

23. Shaughnessy, P.W. and Kramer, A.M. The Increased Needs of Patients in Nursing Homes and Patients Receiving Home Health Care. New England Journal of Medicine, 322 (1): 21-27, 1990.

24. Harrington, C., Swan, J.H. and Grant, L.A. Nursing Home Bed Capacity in the States, 1978-86. Health Care Financing Review, 9 (4): 81-111, 1988.

25. Harrington, C. et al. (1985). Long Term Care of the Elderly: Public Policy Issues. Beverly Hills, CA: Sage Publications.

26. Phillips, C.D. and Hawes, C. Discrimination by Nursing Homes Against Medicaid Recipiens: The Potential Impact of Equal Access on the Industry's Profitability. Research Triangle Park, NC: Research Traingle Institute, 1988.

27. U.S. Department of Commerce/ International Trade Administration. U.S. Industrial Outlook 1990, Health and Medical Services, Washington, D.C.: U.S. DOC, 1990.

28. Estes, C.L. et al. (1983). Fiscal Austerity and Aging. Beverly Hills, CA: Sage Publications.

29. Swan, J.H., Harrington, C. and Grant, L. (1988). State Medicaid reimbursement for nursing homes, 1978-86. Health Care Financing Review. 9 (3), 65-93.

30. U.S. Department of Health and Human Services (U.S.DHHS). Task Force on Long-Term Care Policies (1987). Report to Congress and the Secretary: Long-Term Health Care Policies. Washington, D.C.: U.S. Government Printing Office.

31. Hawes, C. and Phillips, C.D. (1986). The Changing Structure of the Nursing Home Industry and the Impact of Ownership on Quality, Cost, and Access. In For-Profit Enterprise in Health Care. Ed. by B.H. Gray. Washington, D.C.: National Academy Press, Institute of Medicine, 492-538.

32. Fritz, M. (1990). Health. Forbes. (January 8, 1990), 180-182.

33. Vladeck, B.C. (1980). Unloving Care: The Nursing Home Tragedy. New York, NY: Basic Books, Inc. Publishers.

34. Short, P.F., Monheit, A.C., and Beauregard, K. (1989). A profile of uninsured Americans. National Medical Expenditure Survey. Research Finding 1. Washington, DC: National Center for Health Services Research and Health Care Technology Assessment, U.S. Department of Helath and Human Services.

35. Knoefel, G., Office of Medi-Cal Rate Setting. (1988). Personal Communication. Sacramento, CA: California State Department of Health Services.

Note: The author wishes to thank Sister Lucia Gamroth, University of Oregon School of Nursing for her assistance in collecting information on nursing wages and quality in nursing homes.

Mr. WAXMAN. Ms. Burger.

STATEMENT OF SARAH BURGER

Ms. BURGER. Thank you. It is a pleasure to be here to talk on this particular and important subject.

The nursing home reform amendments of OBRA 1987 set a framework for achieving higher standard of care. Without adequate, well-supported staff, we will not be able to fulfill the promise of OBRA.

We applaud Congressman Walgren for opening the discussion on the critical issue of staffing with this proposed legislation. We urge Congress to deliberate on these serious issues and take action to support quality care for nursing home residents.

The most critical issue is that of understaffing. Nurses and nurse aides work short staffed as a matter of routine. This means nursing home residents must go unattended in their personal care needs, and vital services such as maintaining mobility fall by the wayside.

The atmosphere in too many nursing homes is one in which residents are restrained and overmedicated, slowly deteriorating physically and mentally, because of the inability of hard-working staff to meet anything more than their basic needs. This is not the picture in all nursing homes, and so we look to those nursing homes with a dynamic and healthy environment to discover what makes the difference.

We see good management which uses good supervision and support to create a sense of team work among staff. This includes hiring sufficient numbers of staff, including nurses, nurse aides, activity staff, social services personnel, housekeeping and dietary staff.

It also includes a sense that employees are valued as shown through decent wages, benefits including leave time, and creative management strategy such as flexible work hours and support for the other in-staff people's lives such as child care assistance.

Part of this is valuing employees for what they know and can contribute. Nursing homes can do this by including nurse aides in the care planning conference, giving aides complete information about the residents they are caring for, and having permanent aides so they know and can develop relationships with the residents which will promote sensible and knowledgeable caregiving.

Good care practices that support quality of life are based on individualized care. If a nursing home provides good care and respects the quality of life of its residents, there will also be a positive work environment. We have seen dramatic examples of this in the way that facilities have reexamined their use of restraints, have reduced staff turnover and have staff from other nursing settings asking to work at their homes.

As we review Mr. Walgren's bill, we are concerned on four levels. It addresses only one part of the problem, that of wages for nurses and nurse aides.

While this is important to do, we must remember complex problems require comprehensive solutions. This includes attention to the work environment, management and supervision supports for aides, education and training, and addressing the other pressures

aides face in their lives that impinges on their ability to produce their best efforts.

Our second concern is, even if we look exclusively at reimbursement solutions, increased wages by themselves will not lead to more staffing in nursing homes. Nursing homes are limited in how many staff they can hire by State reimbursement systems that may place a cap on direct nursing care expenses. Until we have comprehensive reimbursement reform so dollars are directed to support residents' highest practical mental, physical and psychosocial well-being, we will continue to be understaffed.

Our third concern is that technically, we must assure if we support wage passthroughs, we must have sufficient accounting and auditing practices to assure that public dollars are spent on resident care. The public needs the guarantee that funding is used for direct care cost, not on indirect costs, profit, and/or administrative services.

Finally, we have little faith in the cost estimates associated with improved quality care. As the provider community has discussed its cost estimates related to implementation of the nursing home reform law, it has added up all the cost of increased staff without calculating the impact of staff on residents' conditions. Thus, we hear how much resident assessment will cost but not how much it will prevent poor outcomes. We hear how much aide training costs, but not how much more efficient it will be for aides to have the skills they need to perform the caretaking duties.

We do not believe all good care practices are necessarily more expensive. A facility that works short-staffed will see serious declines in resident conditions, residents losing their mobility and their ability to perform activities of daily living. Residents who become more dependent are also more expensive and time consuming to care for as their needs become more complex and intense. Thus, we have often been penny-wise and pound-foolish. A dollar is saved up front, but now we must spend many more dollars on staff to care for a needlessly sicker person.

Mr. Walgren is to be commended for bringing this important issue to Congress and for providing the catalyst for a thorough discussion of the factors that affect staffing in nursing homes.

Thank you very much.

Mr. WAXMAN. Thank you very much for your testimony.

[The prepared statement of Ms. Burger follows:]

TESTIMONY OF
SARAH BURGER, R.N.
NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM
Before the
HOUSE ENERGY AND COMMERCE COMMITTEE
July 20, 1990
Regarding H.R. 1649

Thank you for this opportunity to testify about the importance of supporting nursing home staff to assure quality of care and life for nursing home residents. My name is Sarah Burger. I am a Registered Nurse and I am giving my testimony on behalf of the National Citizens' Coalition for Nursing Home Reform.

The Nursing Home Reform Amendments of OBRA '87 set a framework for achieving this higher standard of care. Without adequate, well-supported staff we will not be able to fulfill the promise of OBRA. We applaud Congressman Walgren for opening for the discussion the critical issue of staffing, with his proposed legislation, H.R. 1649. We urge Congress to deliberate on these serious issues and take action to secure quality care for nursing home residents.

Our first organizational work was to address the Plight of the Nurses Aide with a working paper we issued in 1978. The issues we identified then had been documented in previous reports, including investigations by the Senate Special Committee on Aging and the House Trailer Committee on Aging. We find these problems still shape the atmosphere in nursing homes today.

Nurse aides provide 90% of the hands-on care that nursing home residents receive. Yet aides are often poorly trained, a situation that will change as the Nursing Home Reform Amendments of OBRA '87 are implemented, beginning in October of this year. While training is a critical issue, other problems affect the quality of the work environment.

The most critical issue is that of understaffing. Nurses and nurses aides work short-staffed as a matter of routine in most nursing homes. This means that nursing home residents must go unattended in their personal care needs and that vital services such as maintaining mobility often fall by the wayside. The atmosphere in too many nursing homes is one in which residents are restrained or over-medicated, slowly deteriorating physically and mentally because of the dismal surroundings and inability of hard-working staff to meet anything more than their most basic needs.

This is not the picture in all nursing homes and so we look to those nursing homes with a dynamic and healthy environment to discover what makes the difference. We see:

Good Management which uses good supervision and support to create a sense of teamwork among staff. This includes hiring sufficient numbers of staff including nurses, nurses aides, activities staff, social services personnel, housekeeping, and dietary staff. In also includes a sense that employees are valued, including decent wages, benefits including leave time, and creative management strategies such as flexible work hours and support for the other demands in staff people's lives, such as child care assistance. Part of this is valuing employees for what they know and can contribute, such as including aides in the care planning conference, giving aides complete information about the residents they are caring for, having permanent assignments of aides so that they know and can develop a relationship with the residents that promote sensitive and knowledgeable care-giving.

Good care practices that support quality of life and are based on individualized care. If a nursing home provides good care and respects the quality of life of residents, it will also be a positive environment in which to work. We have seen dramatic examples of this in the way facilities which have re-examined their use of restraints have seen reduced staff turnover, and staff from other nursing settings asking to work at their homes. Staff would rather help people regain their strength and skills, than mop floors and change soiled clothing. The facilities which are redirecting their efforts toward the "highest practicable physical, mental and psychosocial well-being" of residents find their staff morale is high and that all employees are thinking creatively about how to overcome residents problems and achieve optimal care.

H.R. 1649 is essentially and basically about values. As Congressman Walgren has stated in introducing H.R. 1649, that are values are reflected in the kind of care "we expect for ourselves and our families."

A prime indicator of the quality of a society is how it cares for its weakest and frailest members. The frailest members of our society reside in nursing homes. The residents of nursing homes are our mothers and fathers, aunts and uncles, sisters and brothers, and daughters and sons, neighbors. Our citizens who reside in nursing homes are elderly, chronically ill and frail persons, with the most complex of care needs. These care needs cover the entire spectrum of the human condition -physical, mental and psycho-social well-being. In no other health care delivery setting are issues that deal with the essence of human existence so confronted on a daily, long term basis.

Some of the daily on-going care needs of the nursing home resident relate to death and dying, loss, grieving, human sexuality, ability to communicate, understanding, decision making, control, mood and behavior, in addition to activities of daily living and physical care. Some of these activities concern seeing, eating, walking, eliminating, sleeping, comfort -- all activities of daily living. All of these needs and activities relate to quality of care and quality of life.

As we review Mr. Walgren's bill we are concerned on four levels:

(1) It addresses only one part of the problem, that of wages for nurses and nurse aides. While this is important to do, we must remember that we need comprehensive solutions to complex problems. This includes attention to the work environment -- management and supervision supports for aides; education and training; good care practices; addressing the other pressures aides face in their lives that impinge on their ability to produce their best efforts.

It is clear that to provide quality of care which results in quality of life for nursing home residents, aides need total institutional support. While ninety percent of direct care is provided by nurse aides (who have the fewest skills and the least training and technical knowledge), the average ratio of nurse aide to resident is one nurse aide for fifteen residents. And the average ratio of registered nurse staff is one R. N. for 100 residents. There are not enough nurses and not enough nurses aides to meet residents' needs.

In addition, the knowledge, skills, and attitudes of nursing personnel must be extensive in order to meet the complex needs of each individual resident. The nurses that are there are not always able to provide the supervision, training and management aides need to carry out their

duties. This is because there are not enough nurses to meet all the demands of their job and because nurses are often not well-trained in these skills with no commitment on the part of management to provide for the development of these skills. Too often nursing staff tasks are focused on an endless cycle of deterioration while staff try to keep up with increasing demands. Yet in facilities that have dynamic programs, such as restorative nursing care and engaging activities, residents stay healthier and staff can better meet their needs.

To provide care which addresses and attempts to meet these complex care needs requires extensive knowledge and skill and a humane attitude. It also requires on going and continuing education, constructive evaluation and supportive management.

The values of quality of care and quality of life for residents must be reflected in the nursing facility philosophy. Implementation of a resident-centered philosophy rests on the quality of the nursing staff as evidenced by institutional support assuring the following for nursing personnel:

- Adequate staffing reflecting the real acuity of residents
- Effective and on-going education and inservice
- Nursing supervision and evaluation which is constructive and instructive
- Individualized care plans based on adequate assessments
- Sufficient resources appropriately targeted to implement plans of care which can be reflected in quality of life.
- Wages and benefits for nursing personnel which reflect the value of the role and contribution in providing quality care.

Without support nurses experience job dissatisfaction leading to high staff turnover. Nursing personnel, working under such stress, are unable to provide quality of care and quality of life to residents. The owners and managers of nursing homes have an institutional responsibility for quality care.

There are many management strategies that contribute to staff retention:

■ Factors which relate to motivating staff to provide quality care are:
- Sensitivity to the needs of the adult learner and care giver,
- Participation in care planning and evaluation which indicates respect for the activity and resident experience of the worker,
- Recognition of good care giving
- Participation of decision making in the work environment,

■ One of the most important management activities for better staff morale, employee satisfaction, and low turnover rate is to respond to the life circumstances many nurse aides face. Aides are primarily adult females who are poor and have responsibilities, often as single parents. Benefits which reflect employee needs, such as child care, flexible work hours, medical insurance, retirement benefits and education benefits leading to career mobility make a tremendous difference. Nurse aides, as single parents, often, out of necessity must hold more than one job. Therefore, these workers come to the nursing facility stressed and exhausted and yet they are entrusted with care to the frail and elderly and are expected to be caring. Management strategies must reflect a sensitivity to the total life situation of its workers.

■ Education is critical for aides and nurses. Aides often have minimal literacy skills. Education and constructive supervision is required, appropriate, and necessary on a daily basis to provide quality caring. Aides need appropriate education and training programs, and sensitive qualified staff to implement them. The challenge for the education, training and continuing education activities is to address the complex needs of residents and develop the appropriate knowledge, attitudes and skills aides need. Minimum education for nurse aides is now mandated by law. Resident assessments are also required by law. Licensed nurses must be taught how to perform these assessments and use the resulting information to provide quality care and quality of life for each resident.

■ Clearly adequate staffing is necessary. High incidence of staff turnover is related to work load, burnout, and inability to function in an overstressed environment.

(2) Our Second concern about Mr. Walgren's bill is that even if we look exclusively at reimbursement solutions, increased wages by themselves will not lead to more staff in nursing homes. Nursing homes are limited in how many staff they can hire by state reimbursement systems that place a cap on direct nursing care expenses. Until we have comprehensive reimbursement reform so that dollars are directed to support residents' "highest practicable physical, mental and psychosocial well-being" we will continue to be understaffed.

Appropriate reimbursement certainly is one aspect of providing for quality in residents life and we support efforts to address the critical issue of wages. Reimbursement for nursing personnel which is comparable to other care giving settings indicates the value society places on those needing care and the value of providing that care. The Walgren Bill addresses one aspect of what is vital to provide quality care reflected in quality of life to our frailest citizens.

Although there are more nursing home residents than hospital patients in the United States, the nursing home settings employs less than 8 percent of all nursing personnel. The reimbursement level for nursing personnel entrusted with the care of our elderly and chronically ill is the lowest in all of the health care delivery system. For example, nurse aides who provide direct care in nursing homes receive the minimum wage, less than workers in fast food restaurants.

Why would nursing personnel choose the nursing home setting? In fact nursing home residents reported in our 1985 study, A Consumer Perspective on Quality care: The Residents' Point of View that "Good staff means everything" -- kind, caring treatment by well-trained staff in sufficient numbers is the number one factor affecting quality. Nurses aides report, in other studies that they share this feeling, that the primary reason they work in nursing homes is because they care for their relationships with residents. Dedicated nurses and nurses aides hang in there, in discouraging work environments where they are poorly rewarded, because they care about the people living there. The premise is that workers in these facilities care about residents.

All of this relates to the necessity to have quality staff committed to quality care-giving on a daily, long term basis. Adequate and comparable reimbursement is one factor in assuring job satisfaction, low turnover rate, and high morale on the job. This translates into a labor force which would be adequately reimbursed under the Walgren Bill in turn demonstrating society's values. Wages and benefits must reflect the fact that the institution cares about those providing care to residents. However, increased salaries cannot effect good care unless there is also increased

staffing.

The Walgren Bill addresses one segment of nursing home reimbursement, when, in reality, the total system contributes to inadequate quality and quantity of staff leading to poor resident outcomes. For example, in some states the reimbursement level may be too low or a state cap may force nursing facilities to hire inadequate numbers or mix of nursing personnel. So nursing homes that try to use the wage pass-through to attract more staff will still face limits on the number of employees they can be reimbursed for under such a state's reimbursement system.

Reimbursement systems now are built around a complex array of cost limiters which rarely have much to do with the amount of resources necessary to provide quality care. When this is coupled with unacceptable provider practices, described below, residents and staff suffer. Even reimbursement systems that have gradations based on residents' acuity can have a perverse incentive for poor care -- especially if facility reimbursement goes up as a resident's condition declines.

We must review our reimbursement systems to make sure they promote and support improvement in people's physical, mental and psychosocial function, rather than paying more for unnecessary deterioration. We must not have caps on patient care that leave nursing home's short-staffed and undersupplied. We must discourage those who play real-estate games and engage in financial paper shuffles with our public dollars and the lives of our citizens.

Comprehensive reimbursement reform must target resources for care and must include auditing and accounting practices that assure the funds are spent on care.

(3) Technically, we must assure that if we support wage pass-throughs, we have sufficient accounting and auditing practices to assure that public dollars are spent on residents' care.

Reporting procedures must be implemented which would give a clear picture of how nursing facilities are utilizing pass-throughs. Some states that have used wage pass-throughs forgot to get baseline data on nursing home staff expenditures before the new monies were passed-through.

The public needs the guarantee that funding is used for direct care costs and not on indirect cost, profit, and/or administrative services. Auditing procedures are notoriously lax in most states and bear little connection to care practices. If the numbers add up, it rarely matters to the Medicaid auditors if a facility has been cited for numerous patient care deficiencies.

There need to be regular field audits of the financial records of nursing homes. And there needs to be an active cooperation between the efforts of the Survey and Licensure Agency and those of the Medicaid program. If the surveyors find conditions that warrant adverse actions, such as a ban on admissions, or civil fines, it may very well be appropriate for the Medicaid office to conduct a field audit to determine how public dollars are being spent by the facility.

(4) We have little faith in the cost estimates associated with improved quality care. As the provider community has discussed its cost estimates related to implementation of the Nursing Home Reform Law, it has added up all the costs of increased staff without calculating the impact of staff on residents' conditions.

Thus we hear how much resident assessment will cost, but not how valuable it will be to know a resident better and therefore be better able to take care of them. We hear how much aide training costs but not how valuable and more efficient it will be for aides to have the skills they need to perform their care-taking duties. We do not believe that all good care practices are necessarily more expensive. A facility that works short-staffed, will see serious declines in resident conditions -- residents become more and more dependent as they lose their mobility and other abilities in activities of daily living. They become more and more expensive and time-consuming to care for as their needs become more complex and intense. Thus we have been penny-wise and pound-foolish, saving a dollar on staffing so that we now must spend many more dollars on staff to care for a needlessly sicker person.

Prevention is more efficient and economical than treating results of poor care. Many of the more common reasons for neglect in nursing homes can be prevented. For example, decubiti is preventable by daily assessment and diligence. The financial cost of treating decubiti is $1.5 billion annually, by one recent estimate. The cost to the resident is physical and mental neglect and abuse. Increased staffing levels and higher wages and benefits can add to ensuring the prevention activities necessary to attain quality.

Proper bowel and bladder regimens are humane as well as more cost efficient than treating the results of incontinence. A study "Profile of Urinary Incontinent Elderly in Long Term Care Institutions" by Yu, et al Journal of the American Geriatric Society found that incontinence stems from other mental and physical disabilities which respond to prompted toileting, such as dementia and poor mobility, rather than primary bladder problems. Rehabilitation is more cost effective than treating the multiple ill effects of this individualized care.

Low staffing is used as an excuse for use of chemical and physical restraints. Restraints always lead to decreased quality of life and often to poor outcomes such as skin breakdown, urinary tract infections, pneumonia, and contractures. These outcomes are expensive to treat leading to increased skilled nursing services, hospitalizations and increased use of expensive supplies and drugs.

The HHS Commission on Nursing reported in November 1988 that the cost of increasing wages is offset by reducing staff turnover and decreasing recruitment costs. In addition, quality and quantity of nurses is higher, resulting in better care-giving and reduced numbers of costly poor outcomes. Finally, the frail older member of our society, who we will someday be, will be the beneficiary of individualized humane care.

Mr. Walgren is to be commended for bringing this important issue to the Congress and providing the catalyst for a thorough discussion of the factors that affect staffing in nursing homes. We have an opportunity to make public policy catch up with our values. The Nursing Home Reform Amendments of OBRA '87 were a good start. But we will not realize the full promise of those reforms until we invest financially and otherwise, in those staff persons who must carry out its mandate.

Mr. WAXMAN. Dr. Harrington, in your written statement you indicate nursing home rates increased 11.2 percent between 1988 and 1989. According to the American Health Care Association, over 70 percent of the average daily cost of providing services in a nursing home is attributable to labor. The Congressional Research Service estimates that over 60 percent of the nursing facility labor force are nursing personnel.

My question is, did wages and benefits for nurses and nurse aides go up 11.2 percent last year? If not, what accounts for this large increase in nursing home rates? If all of the additional money is not going to the nurses and nurse aides who provide direct patient care, where is it going?

Ms. HARRINGTON. We don't know exactly what happened in terms of wages for 1988 and 1989, because it is too early to have the data. But we know that for the past 10 years hospital and nursing home costs have gone up between 9 to 11, even 15 percent, and we know that for that 10-year period, in general, the nursing wages have only gone up around 4 percent. The wages are not being passed through to the employees.

In terms of where does the money go, I think that is a good question.

Mr. WAXMAN. The wages are not being passed through?

Ms. HARRINGTON. The increase in revenues that hospitals and nursing homes experience are not going to the personnel, because their increases have only been about 3, 4, 5 percent over the past decade. So the money that the nursing homes are getting in terms of increased revenue is primarily going for increases in profits.

Seventy-five percent of all the nursing homes are proprietary so money is going to investors and owners. It is going to help finance expansion of chain operations. Today, 41 percent of all the nursing homes in the United States are part of multifacility operations.

The money is also going to increases in administrative costs, to purchases of real estate, and to expanding operations. It is not going, unfortunately, to the workers.

Mr. WAXMAN. In your written testimony, you state that "some nursing homes encourage high turnover rates to keep wages low." If true, this has extremely troubling implications for our ability to assure quality care for nursing facility residents.

Can you document this? How can we discourage this practice?

Ms. HARRINGTON. It is very difficult to document this, because it happens on an individual level. But we know, in general, that nurses and nursing employees reach their peak in terms of their earning capacity within about 4 years of employment. This is true not only in nursing homes, but also in hospitals.

So after the 4 years, if they cannot earn any more money, they are very likely to leave. But also we know that nursing homes, as they have to increase wages, prefer to have the lowest level employee in some facilities, because they can save money. So this is definitely a problem.

It depends on the way the States reimburse nursing homes, but in general nursing homes and hospitals are keeping the maximum levels at a very low point. We call this a "compression of wages."

Mr. WAXMAN. In your written testimony, you cite California's experience in providing additional funds for nursing personnel and

nursing facilities. You indicate that "some nursing homes only partially passed on the funds of their personnel, while 20 percent of the facilities made no wage passthroughs to nursing personnel."

What happened to the funds allocated by the State for nursing personnel but not passed on by the nursing facilities? Did the facilities return the funds to the State? What did they do with the extra money?

Ms. HARRINGTON. We don't know exactly what the nursing homes used the money for. Some of them may have put the money in the bank and accrued interest on it. Others may have used the money for other purposes other than wages and benefits.

The unfortunate thing is that even though States may do desk audits for nursing homes on an annual basis, they frequently don't do a full audit on a nursing home except every 3 years. Sometimes they are way behind and don't even do it every 3 years. So by the time they actually do an audit and determine the nursing home didn't pass the wages and benefits through, it could be 3 to 5 years later. We know some nursing homes are only being audited right now in 1990 for 1986.

We also know the recovery rates by the Medicaid programs are very, very low. So it is doubtful that a lot of the money was ever recovered.

Mr. WAXMAN. Thank you.

I just have one last question I want to ask Ms. Burger, even though my time has expired.

As I understand your testimony, it is your view the most critical issue is not the wage and benefits level for nurses and nurse aides, but understaffing. In this connection, you note that "nursing homes are limited in how many staff they can hire by State reimbursement systems that place a cap on direct nursing care expenses."

There is no such cap in Federal law and I am frankly surprised that HCFA would allow States to impose such caps if they lead to understaffing.

Can you give us some examples of States which have such caps and can you describe how they work?

Ms. BURGER. I can't give you an example although I will try to get some for you and report back to you.

It is well known that Medicaid budgets are way down and, indeed, often they are specific in a particular part of the Medicaid reimbursement system. I will get that information for you.

Mr. WAXMAN. We will hold the record open.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

I would like to ask the panel, we know that the problem is low wages, improper benefits, which equate to improper staffing, inadequate staffing but I would like to get to the reason.

Is reimbursement from Medicaid and Medicare the principal reason why you have such differences in the pay scales? And I am not for one moment indicating the pay scales for registered nurses in hospital, for instance, are adequate, because I spoke to a registered nurse yesterday who worked on the Hill for sometime and now is working with the American Bankers Association downtown,

and is a registered nurse. And I asked her why, and she said, "Money, very simply."

I am certainly not indicating it is adequate as far as hospitals go, but why is there such a differential? What would you say the reason would be? Is it principally reimbursement?

Ms. HARRINGTON. Yes, I think it is principally reimbursement. Medicaid pays almost half of all the nursing home bills. So the policy decisions made by Medicaid tend to carry for the whole industry.

The other thing is that many States don't have strict controls on where the money goes once they pay the money to the nursing homes. That is particularly true in California where they pay a flat rate.

So nursing homes are allowed to try to keep wages and benefits low so they can maximize their profits.

Mr. BILIRAKIS. So it is really not all reimbursement but it is part of it.

Ms. HARRINGTON. Medicaid low reimbursement is part of the problem. But so is not specifying where the money should go within the reimbursement system.

Mr. BILIRAKIS. And that is a State thing?

Ms. HARRINGTON. It is done on a State-by-State basis.

Mr. BILIRAKIS. How about the Medicare reimbursement, where there is coverage by Medicare for nursing home care which we know is very limited? But in any case, how does the reimbursement for nurses insofar as Medicare is concerned compare, nursing homes versus hospitals?

Ms. HARRINGTON. The Medicare reimbursement is higher, significantly higher in many States. So it does pay better and you do see better staffing for Medicare beds.

But I also want to mention one thing about the nursing home market. It is very different from the hospital market. With hospitals you only have a 65 percent occupancy rate. Those hospitals are competing on the basis of quality. You also have a very low proprietary rate. Only 15 percent of hospitals are proprietary.

Nursing homes are an entirely different industry because they have a 92 percent occupancy rate. They have so many patients that are demanding to get in, they don't have to compete on the basis of quality. They don't have to hire enough adequate nurses to really get patients in. Patients have to get in anyway. Also, because 75 percent of the nursing homes are proprietary, they are trying to make a profit for their investors and their owners whereas you don't have that same incentive with most hospitals. So you have the market putting this pressure to maximize profits and keep wages and benefits low in nursing homes.

Mr. BILIRAKIS. All right. Very well said, and certainly a very, very good point, and I am sure it is a very realistic, real-world point.

But, again, getting back to Medicare reimbursements, the portion of the Medicare reimbursement which is attributable to the registered nurse, are they different? Are we saying that portion is different in nursing homes versus hospitals? Is the Federal Government——

Ms. HARRINGTON. Yes, because Medicare pays a different rate.

Mr. BILIRAKIS. Medicaid, but I mean Medicare.

Ms. HARRINGTON. Medicare nursing home rates are higher than Medicaid rates. I think those two rates ought to be brought closer together. There is no major reason to have such a differential between Medicare and Medicaid rates. Those differentials can be as high as at least 15 percent.

Mr. BILIRAKIS. Forgive me. I am trying to get to the Medicare portion.

Mr. Chairman, I don't know if I am making myself clear.

The Medicare portion that is reimbursed by the Federal Government, is there a distinction between the portion for the registered nurse in one cases versus the other?

Ms. HARRINGTON. Yes, between—absolutely, between acute and long-term care. The Medicare rate for nursing homes is lower than it is for hospitals, but significantly higher than the Medicaid rate. So we need to bring those two rates together.

The Medicare facilities are able to hire more nurses. But remember, Medicare only pays for 2 percent of the country's nursing home bill.

Mr. BILIRAKIS. Thank you.

Mr. WAXMAN. Mr. Walgren.

Mr. WALGREN. Thank you, Mr. Chairman, and I apologize for not being able to be here during your testimony.

I hope the point is not cumulative, but what can be said about the satisfaction or dissatisfaction of families with relatives in nursing homes? In your contact with them, is it universally disappointment, or how can you characterize the satisfaction of families with the services that their family member receives in a nursing home?

Ms. BURGER. I think there are a couple of factors that impinge on this.

Yes, indeed, there are families who are very dissatisfied, those families who have learned what good care can be and what should happen to their relative in a nursing home. On the other hand, many families really don't know what good care is—they don't know what to expect in a nursing home. This is one of the things we spend a lot of time doing, helping families understand that there is a difference between good care and bad care.

When a nursing facility is approached by a family who says, "why is mother wet", or "why is mother no longer walking", or "why does mother have bruises", the nursing home always has an answer which sounds quite logical to an uneducated consumer. This is a very complicated business.

And so there is also something—"your mother is very old and therefore her skin bruises very easily". That is true, but you can handle her more gently. Or we hear "your mother is so old her bladder doesn't work very well anymore". That may not be true. It may be mother needs to be taken to the bathroom at her moment of needing to go.

So it is these things the consumer is faced with, of saying, "I think something is wrong here". And the facility, obviously, is going to say, "of course there is nothing wrong". Families often need a great deal of education. So it is a hard question to answer.

Those who have the information often are quite upset, except where they're involved with those nursing homes that do a good job. There are some of them.

Mr. WALGREN. Can anything further be added to that?

Ms. HARRINGTON. I certainly agree there is a lot more dissatisfaction with the quality of nursing home care than there is with hospital care. I think that is evidenced by the fact there is no other sector of the health care industry that has had such poor ratings in terms of facilities not meeting minimum standards as there are in nursing homes. I really find this is directly attributable to the issue of staffing. Nothing else is as important as that staffing issue.

Mr. WALGREN. In the reforms that we passed just a year or so ago, there was a theme that ran through them that I wonder whether it couldn't be built on, and it was along the idea that if you could increase the level of professional expectation on the supervisory level, that then you would be able to increase the level of care given by the range of people who are spending more direct time and contact with the patients.

When you see numbers like 6 minutes and 12 minutes, obviously we are not in a position to put registered nurses in contact with the patient for hours and hours a day, but we should be in a position to have such—it seems to me we should be in a position to have such a comparable level of wages that the person that would be in the supervisory position would have high professional standards that could then be drawn out of the nurse aides and the licensed practical nurses and the others that are in contact with the patient.

Do you see that kind of model of the supervisory level being brought up, and then that having a kind of a rising all hands in the facility effect?

Ms. HARRINGTON. I think that is absolutely the case. I think there is clear evidence that if we had more nurse practitioners and clinical nursing specialists and better educated nurses in gerontology, there would be much stronger results in terms of quality of care.

Yet nursing homes are not able to hire these people in many cases because the wage rates and the reimbursement rate is so constrained, they feel they cannot afford to hire these highly trained nurses. We are training nurses from our nursing school, and they can't get jobs in nursing homes because the nursing homes can't afford them.

Mr. WALGREN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Walgren.

Mr. Whittaker.

Mr. WHITTAKER. Thank you, Mr. Chairman.

The Congressional Budget Office has estimated the 5-year Federal cost of H.R. 1649 is in the neighborhood of $2.6 billion. Because of the Medicaid matching requirement, fiscal impact on the State would be about the same.

The governors that have discussed this with the committee are strenuously arguing that they can't afford any more Medicaid mandates. Congress and the administration, as you are very much aware, are in budget negotiations right now to try to find a way or ways to cut the deficit.

Can you think of any other possible option that might exist to address the problem that will not be quite so costly?

Ms. HARRINGTON. I want to first of all argue that this is a cost savings, in effect. The data that I cited earlier show that we could have saved almost a billion dollars last year alone in hospitalization costs if we had better trained nurses in nursing homes. If you had a billion dollars a year from that one factor alone, that adds up to $5 billion within 5 years. If your cost estimate here is only $2.6 billion, you are actually going to save money.

The problem with these analyses, they only look at nursing home costs—what is the increase to nursing homes. They do not look at offsets, at savings to hospitals and other parts of the Medicaid budget.

So I hate to try to think of ways to reduce the cost. But, of course, this bill is proposed to be phased in over a 5-year time period and that is one way to help with the initial cost of it.

I think with the amount of money we spend on trying to improve quality through regulation, we could do a lot better with quality if we just put the money into wages and make sure the nursing homes put it to that use instead of into profits.

Mr. WHITTAKER. Ms. Burger, would you care to comment?

Ms. BURGER. I would certainly agree with what Dr. Harrington said and would reiterate, indeed, that we are being penny-wise and pound-foolish by paying for our nurses in nursing homes, and then not giving them enough staffing to do the job, and having to then pay the higher cost of the residents when they are transferred to an acute care facility, or transferred from intermediate to a skilled care part of the facility where there is a higher nursing staff. That staff can bring the person back to a level of health such that he or she can go back to the intermediate floor that has less staff. Then the cycle begins again, so they are moved to a higher level of care. We are just wasting our money.

Mr. WHITTAKER. Thank you, Mr. Chairman.

Ms. BURGER. Prevention.

Mr. WAXMAN. Thank you, Mr. Whittaker.

Mr. Nielson.

Mr. NIELSON. Dr. Harrington, in your testimony you mention lease back arrangements, creative financing mechanisms and other type real estate speculation, and other things which may not be too appropriate. How does the economics in financing in nursing homes differ from the economics in hospitals?

Ms. HARRINGTON. The prime way it differs is that most nursing homes are proprietary. Seventy-five percent are proprietary and many of those are chain nursing homes. These nursing homes, while some of them have recently had some financial problems, are still making very high returns on their investment. I wanted to point out that two national nursing home chains made 14 to 17 percent returns on equity in 1989 over the previous year, and 13 to 22 percent earnings per share for the last 10 years.

This is one of the most profitable businesses and this is the main difference between nursing homes and hospitals. There is such a tremendous pressure to increase revenues over expenses to pay for profits in nursing homes. So you have tremendous pressure to keep wages low.

Mr. NIELSON. Because they make so much money they are able to speculate, buy and sell this type of thing?

Ms. HARRINGTON. Yes, and it is used to expand the operations, to buy more facilities.

Mr. NIELSON. What you are describing is foreign to my district. My district has a number of nursing homes in rural areas, and they are having struggles. They are having a hard time keeping it open. I live in an area which is the size of Indiana, with lots of nursing homes in it.

I have a statement I would like to enter into the record, Mr. Chairman, if that is possible.

Mr. WAXMAN. Without objection.

[The prepared statement of Mr. Nielson follows:]

PREPARED STATEMENT OF HON. HOWARD C. NIELSON

Chairman Waxman, colleagues and witnesses, I am pleased to participate in these hearings today. If the nursing shortage in our Nation's hospitals is in serious condition, the nursing shortage facing nursing homes is in critical shape. The cause of this ailment is pay. Nursing home nurses and aides often receive inadequate compensation for their long hours and hard work. A recent conversation with one of my constituents reveals many of the problems.

John Bramall, administrator of the Emery County Nursing Home in Ferron, Utah, said that during the 5 years he has been a nursing home administrator, the need for RN's increased dramatically. It is especially acute in rural areas, such as Ferron. Eventually, nursing shortages could cause patients to not receive the care they need. "The problem is of too few nurses receiving too little pay. This exists not only in Utah, but in nursing homes all across the Nation," my constituent said.

John Bramall, who served as president of the Utah Health Care Association, also spoke of the challenges confronting nursing home aides. "A worker at our town hamburger stand can earn the same pay as our nurse aides. Compare making malts and fries with having to diaper, feed, shower, shave and bathe patients, chart all their intake and output and help provide for their recreational and social needs." He concluded that he wishes they could pay them more, but that the money just isn't there.

The pay problem facing nursing home care providers must be addressed. Therefore, I am glad Chairman Waxman is holding these hearings. They will help dramatize the inadequacy of nursing home wages.

However, while I recognize the symptoms, I'm not certain if H.R. 1649 is the cure. It calls for a great deal of money at a time when our Nation's budget is in an intensive care condition . . . if not already comatose.

I am also concerned with the administrative burdens H.R. 1649 would place on the States. We must accept that some of the burdens facing nursing homes and nurses may be our fault and some of the solutions may not be financial. We here at the Federal level continue to write more regulations that are costly to carry out. We call for more charts, more reports, more forms. Said Annetta Mower, a nurse in Emery County, Utah: "We registered nurses often can't give direct nursing care because of excessive bureaucratic papers we are obliged to fill out. The limited time nurses have to spend with each patient continues to diminish as the pile of paperwork increases."

This, while not the entire problem, certainly is a part of it and one I believe should also be addressed.

Chairman Waxman, I am impressed with the fine witnesses you have here today and look forward to hearing their testimony.

Mr. NIELSON. I have a daughter who is a registered nurse who worked in a nursing home. I have a sister who has worked in a nursing home and a niece who worked in a nursing home. None of them do now. Now they work in hospitals, except my daughter, who is staying home to take care of children. She loved the nursing home, she loved the chance to provide personal attention. She felt she contributed more to society when she worked in the nursing home than she did when she worked in the hospital, but she

couldn't stay there because the wage was about $50 less than what she could make in the hospital up the street.

And there is a lineup of everyone who works in the nursing home in the Provo, UT area, waiting for opportunities to join the Utah Valley Hospital, which is the highest paying nursing facility there.

She said a lot of things there could be done by nurse aides and LPN's, would not require registered nurses, and yet the State of Utah requires a registered nurse be in charge at all times. Many of the rural facilities can't attract registered nurses, can't find them.

Are we requiring too much on that level? I realize you are for having as much education in nursing as possible and I agree, but I am wondering, are we so insistent on the degree that we don't make opportunities available to get good help?

Ms. HARRINGTON. I sympathize with the nurses that have left nursing homes and really want to stay there. I think you are exactly right because of the wage situation, but I don't agree we need less registered nurses; I think we need more.

In rural areas—I come from rural Kansas myself, so I am very familiar with the rural problems—the wages are kept artificially low in some cases because they know that nurses that live there, they have to have a job in that area. They are not so mobile whereas if a nurse is mobile, she will come to San Francisco.

Our starting salary in San Francisco is $36,000. So nurses like me may pack their bags and go to San Francisco. Nurses in rural areas are competing nationally. They have to get these wages up if they want to attract high- quality people. I think they need more registered nurses rather than less.

Mr. NIELSON. I am not saying less registered nurses, I am saying some areas in the country it is not possible to get a registered nurse around the clock. You might get one for one shift.

Ms. HARRINGTON. The reason you don't have enough is the artificially low wages. Many nurses want to stay in the rural area. They are forced by the economics to move to the big cities because of the artificially low rate.

I also wanted to point out that you would be surprised how many of the rural nursing homes are a part of national chains where money is going back to the chain operation headquarters. Maybe the nursing home itself doesn't have enough money, but the chain is doing well in this overall financial picture.

Mr. WAXMAN. I do thank you for your testimony. We may have additional questions.

Each of the witnesses on our next panel represents the actual or "hands-on" providers of nursing and nursing-related services in nursing facilities around the country.

Ms. Pat Scuffle, a registered nurse, is with the Forbes Center for Gerontology in Pittsburgh, PA. Ms. Scuffle is testifying on behalf of the American Nurses Association.

We also have with us a representative of the two largest unions where membership includes nurses and nurse aides. Appearing on behalf of the American Federation of State, County, and Municipal Employees is Ms. Kathy Sackman. She is a registered nurse and serves as international vice president of AFSCME, as well as co-chair of the United Nurses of America. Mr. John August is testify-

ing on behalf of the Service Employees International Union. He is president of SEIU's Local 1199, and serves on the union's health care division board.

Our last witness on this panel is Mr. David Kesterson, who is executive director of the National Federation of Licenses Practical Nurses, Inc.

I want to thank each of you for coming this morning to testify before our subcommittee. Your prepared statements will be in the record in full. We would like to ask you to limit the oral presentation to no more than 5 minutes.

Ms. Scuffle.

STATEMENT OF PAT SCUFFLE, ON BEHALF OF THE AMERICAN NURSES' ASSOCIATION; KATHY SACKMAN, VICE PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES; JOHN AUGUST, PRESIDENT, LOCAL 1199P, SERVICE EMPLOYEES INTERNATIONAL UNION; AND DAVID KESTERSON, EXECUTIVE DIRECTOR, NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.

Ms. Scuffle. Thank you, Mr. Chairman.

Mr. Chairman, and members of the subcommittee, my name is Pat Scuffle. I am a registered nurse.

The American Nurses Association is pleased to testify about the effects that H.R. 1649 may have on recruitment and retention of nursing personnel employed by nursing facilities. Our complete written testimony has been submitted to the subcommittee.

For 12 years I have been the Executive Director for the Forbes Center for Gerontology in Pennsylvania. It is a 126 bed facility where half of our residents have Medicare or Medicaid as their primary payer.

We are also concerned about LPN's and nursing assistants, though there is less data available for them. The American Hospital Association reports the RN vacancy rate to 10.6 percent in hospitals. ANA's survey of 1,000 nursing facilities reported an 18.9 percent vacancy rate among nursing facilities.

The ANA survey of nursing homes identified resident outcomes attributable to the very high RN vacancy rates. They include reduced quality of care, closed beds, delayed or reduced admissions, increased recruitment time, heavier workload, increased medication errors and unobserved medication side effects. Also, increased resident falls.

Those findings are similar to those documented in the literature. Let me mention two of the studies which recommend improvements in salaries and benefits. A 1988 Federal study surveyed over 2,600 RN's employed in nursing facilities and 30,000 employed RN's employees in hospitals.

The most important retention factors to nursing facility employees were salary and benefits. The recommendations to the Secretary's Commission on Nursing in 1988 urged pay raises based on experience, performance, education and leadership.

The commission noted that retention in nursing homes is substantially linked to salary and salary compression. In Pittsburgh's

nursing facilities, in many cases, the starting salary basically is the maximum salary.

There are 1,100 distinct hospital-based skilled care facilities across the country and 119 nursing home care units adjacent to the VA Medical Centers. Many of these skilled nursing facilities and all the VA facilities provide wages and benefits which are the same for employees whether they work in a nursing facility or in an adjacent hospital. In skilled nursing facilities with the same wages and benefits, we find the recruitment and retention experience is as good as, or even slightly better than, the experience of the adjacent hospital.

H.R. 1649 does not address already too low staffing standards, nursing salary compression, or the benefit packages for nursing facility employees. A rigorous auditing mechanism is also needed. Wage comparability provisions must include part-time as well as full-time employees. This bill is not the total answer to problems affecting nursing facility care.

Other problems such as social security policies that allow older nursing personnel to work for longer periods, that is through any given year, must be addressed. Another incentive is employer-pay continuing education courses for medication and nursing practice updates and instruction on newer interventions with special resident populations.

We believe this bill shows one approach which fulfills the Institute of Medicine's major recommendation from its 1986 report. I quote:

> Nursing homes should place their highest priority on the recruitment, retention and support of adequate numbers of professional nurses who are trained in gerontology and geriatrics to assure an adequate number and appropriate mix of professional and nonprofessional nursing personnel to meet the needs of all types of residents.

We are grateful for your continuing thoughtful work for the benefit of the Nation's nursing facility residents. I thank you for this opportunity to testify.

[Testimony resumes on p. 76.]

[The prepared statement of Ms. Scuffle follows:]

TESTIMONY

of the

AMERICAN NURSES ASSOCIATION

I am Pat Scuffle, R.N., a member of the Pennsylvania Nurses Association and for twelve years the Executive Director of the Forbes Center for Gerontology in Pittsburgh, Pennsylvania. I am pleased to describe my professional nursing experience which I believe is representative of other nursing facility directors of nursing or nursing home administrators. Our facility has 126 beds and all are dually certified for skilled and intermediate care. For about half of our facility residents, Medicaid or Medicare are the primary payors for their care. I will describe briefly the many competing forces which affect my ability and that of my peers in nursing facilities to recruit and retain nursing personnel at all levels .... registered nurse (RN), licensed practical nurse (LPN) and nursing assistant.

The American Nurses Association (ANA) and the 200,000 members of its 53 state and territorial nurses associations welcome this opportunity to testify about the effects H.R. 1649 can have on recruitment and retention of nursing personnel employed by nursing facilities. This Subcommittee and the full Committee have worked diligently to develop standards to improve the quality of care in nursing facilities. ANA commends Representative Walgren and this Committee for its continued attention to nursing facility resident care and quality improvement. I believe nurses, residents and families welcome the attention and intent of the Nursing Home Reform Act provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) and are grateful to this Committee for that significant achievement. We've worked diligently with this Committee to refine that legislation and are working toward its effective implementation.

This Committee is well aware, too, of the extent and detail of the nation's nursing shortage. The nursing shortage applies primarily to registered nurses, but also includes licensed practical nurses and nursing assistants. Turnover rates are also related to the nursing shortage. The 1986 Institute of Medicine study which became the springboard for the OBRA 87 Nursing Home Reform Act documented a 70-100 per cent turnover rate among nursing assistants in nursing homes. In some parts of the nation, nursing assistants are still paid at minimum wage with limited benefit packages. For reasons related both to the shortage and to the employment situation of nursing assistants, we are very pleased that this bill addresses all groups of nursing personnel.

There are numerous, good sources of data for the RN nursing shortage, especially among hospital employees. There are fewer studies of vacancy rates among non-hospital employers of nurses. Very little data exists about vacancy rates among LPN positions and nursing assistant positions. The American Nurses Association's own data just released last month provides survey responses of a thousand nursing facilities across the nation. This survey reported an 18.9 per cent RN vacancy rate among nursing facilities, significantly greater than the 10.6 per cent RN vacancy rate for the nation's hospitals, as exhibited in the American Hospital Association most recent national survey.

Although both hospitals and nursing facilities are very diverse in their size, structure and operations, there are typically fewer management and resident care options available to nursing facilities to deal with a vacancy

rate of nearly 19 per cent. A vacancy rate of that magnitude cannot be "managed away" by manipulating overtime, shifting scheduled time off, delaying admissions or moving personnel from other departments to assist in non-resident care tasks. These management strategies used to cope with the shortage eventually fail to achieve desired results.

The ANA survey of nursing homes also identified resident outcomes attributable to these very high RN vacancy rates. These outcomes included:

- reduced quality of resident care
- closing beds and delayed or curtailed admissions
- increased time to recruit RNs to fill vacancies (since practicing nursing in facilities which have personnel shortages is not viewed as attractive or rewarding)
- heavier work load on remaining staff and increased overtime (leading to burn-out)
- increased medication errors and unobserved medication side effects
- increased falls among residents.

These findings are similar to those in the literature which identify additional outcomes associated with inadequate numbers of RNs:

- increased resident dependency on staff (since RNs were not available to direct and provide restorative and rehabilitative care which leads to maximum independence in eating, dressing and toileting, for example)
- increased use of psychotropic drugs
- increased incontinence and skin care problems
- increased use of restraints
- increased transfers to acute care hospitals.

It is clearly in the best interest of residents, providers and insurers to reduce and to avoid RN vacancies, as well as vacancies of LPNs and nursing assistants.

Responses to the Shortage

The profession of nursing has responded to this shortage with a variety of initiatives. The profession has the highest ever RN workforce participation. Fully 80 per cent of RNs are employed in nursing, as reported by the most recent data from the U.S. Public Health Service, Division of Nursing. This is an extremely high workforce participation compared to other predominately female professions. Nursing school enrollments are now increasing, reversing a downward trend over the past few years. These outcomes are thanks to the availability of education funds and programs provided through the Nurse Education Act authorization. However, the nursing shortage is continuing and the long term balance between need and supply of registered nurses remains a public policy concern.

A number of studies have recommended improvements in salaries and benefits as a major strategy to address the nursing shortage, especially in nursing facilities. The 1988 final report of a joint publication of the U.S. Public Health Service, Division of Nursing, and the National Center for Health Statistics studied more than 30,000 hospital RNs and 2,600 RNs who worked in nursing homes. The report compared the characteristics and concerns of RNs who work in nursing homes with those of RNs in other employment settings. Nurses ranked 45 factors in terms of how they were related to RN retention as

nursing home employees. The most important factors in this very large study related to salary and benefits provided by the nursing home employer. These factors were salary and several salary-related issues such as increases with merit and differential increments for shift and holiday work, as well as health insurance and retirement plans.

Another report is the December, 1989 set of recommendations from the Secretary's Commission on Nursing. This report discussed the inadequacy of nurse compensation and the severe wage compression characteristic of a nurse's career. The Commission recommended increases in RN relative wages targeted to institutional differences (such as nursing facility versus hospital), as well as compensation options such as pay ranges based on experience, performance, education and demonstrated leadership. The Commission also reported that over the years in which the National Sample Survey of Registered Nurses has been conducted, the gap has widened between the average wage of nurses working full time in hospitals and the average wage of those working in nursing facilities. The Commission noted that retention of RNs in nursing homes is substantially linked to salary. One year retention is 64.6 per cent for those nurses earning under $300 per week, compared to 83 per cent retention for nurses earning $500 or more per week. I note that in the Pittsburgh area, hospitals provide starting salaries for RNs which are significantly greater than for RNs in nursing facilities. Hospitals also typically provide salary increases at three months and six months. For the nursing facilities I'm familiar with, the starting salary for nursing facility RNs is at the same time the maximum salary for that RN job category. In other words, salary ranges are VERY compressed for nursing home RNs.

The nursing facility setting has many barriers to implementation of the recommendations from multiple studies of the nursing shortage. Medicaid's low reimbursement rates for nursing facility care makes it difficult to offer salaries and benefits competitive with other nursing employers, especially hospitals. The nursing home industry's data and that of the U.S. Department of Health and Human Services report a 15 per cent to 35 per cent disparity between salaries of nursing home nurses' salaries and their hospital counterparts.

An important inference about the significance of wage parity between nursing facility RNs and hospital RNs can be made from hospital-based skilled nursing facilities and the experience of the Department of Veterans Affairs. There are more than 1,000 skilled nursing facilities across the country which are distinct parts of hospitals, often located in the same building or on the same campus complex as the hospital itself. Typically these facilities provide employees the same salary and benefits as the hospital. It is our belief, supported by anecdotal data and a quick survey, that recruitment and retention of nursing personnel in those hospital-based, distinct part facilities is no worse than for the hospital at large. That is, when salaries and benefits are the same, the recruitment and retention experience of skilled nursing facilities is no worse than that of the adjacent hospitals. A more easily demonstrated example can be drawn from the experience of 119 nursing home care units which are distinct parts of some of the nation's 172 Department of Veterans Administration facilities. There also, the same salary scales and benefits apply to nursing personnel whether employed in the nursing home care unit or in the adjacent V.A. hospital. It is our best information

that, if anything, these V.A. nursing home care units have slightly better RN recruitment and retention experience than their hospital neighbors.

H.R. 1649

We are pleased to support the intent of this bill. We expect this bill to improve the recruitment and retention capability of nursing facilities. We expect that this bill will send a clear message to nursing home staff that "your work is important here". We believe the bill will send a clear message to nursing home residents that "your life is important here." We anticipate that efforts such as these will improve labor-management relations, as well as consumer concerns regarding good faith recruitment and retention efforts on the part of nursing facilities. We believe this bill will address more recent and very welcome consumer attention to the plight of nursing assistants in nursing facilities who are too often the nation's most dramatic examples of employees whose important work is very inadequately matched by salary and benefits.

We do have concerns about the bill. We do not expect this bill to have an impact on ensuring high quality care nor adequate restorative and individualized care for nursing home residents since the bill does not affect the already too-low staffing standards which are not adequate even for minimally safe care in this era of sicker residents with more complex needs. The current range of 3.6 to 8.4 RNs per 100 nursing facility residents for 24 hour care, seven days a week is deplorable (NCHS, 1988).

We also do not expect the bill will provide incentives to attract enough highly qualified RNs to nursing home employment. The results are just becoming available from the Robert Wood Johnson Teaching Nursing Home Project. In those eleven demonstration sites across the country, there was dramatic evidence of improved resident outcomes subsequent to the enrichment of nursing home staff by nurse clinicians and nurse administrators well prepared in gerontology. This bill also does not appear to address the salary compression between starting nurse salary and peak-of-career salary.

This bill will not address issues of management in nursing facilities. That is, nurses make choices of employment based on perceived leadership within the facility. Taunton and others at the University of Kansas Medical Center, School of Nursing, are studying the relationship of management and leadership behaviors of nursing managers and the subsequent retention of RNs, nurse productivity and selected patient outcomes. Though this study is examining nurses in hospitals, it is reasonable to infer that leadership and management in nursing homes are also related to retention and resident outcomes. When nursing facilities are experiencing nursing personnel shortages and the numbers of highly qualified nurses are lacking, even the present outstanding and heroic dedication from nursing facility staff will not achieve the good management that comes with adequate numbers of registered nurses well prepared in gerontological nursing and in nursing administration.

This bill does not address non-salary benefits of an employee compensation package which are crucial tools in recruitment and retention. Since the current work force of RNs employed in nursing homes is somewhat

older than RNs in other employment settings, salary is only one factor utilized when selecting employment. Whether small or large, a nursing facility may not offer a retirement plan, health insurance (or health insurance which covers families), day care for children, tuition reimbursement, paid consultation with nurse experts, or paid registration for continuing education conferences as well as paid time off to attend those conferences. The bill's provisions do not appear to calculate the very difficult to quantify characteristics of those non-salary benefits which we believe are significant factors in recruitment and retention.

Additionally, it is not clear how the baseline salary data will be established. Attention needs to be paid to this to avoid gaming. We note that there are no penalty provisions in the bill for those facilities which do not demonstrate that they used the proposed pass through funds for enhancement of wages for nursing personnel. It is not clear to us if the bill has a statutory mandate to raise nursing personnel wages and, if so, if the mandate is to raise wages to the community rate or only to the minimum rate. It is not clear how non-taxable benefits are to be incorporated in the calculation of community prevailing wages (tuition reimbursement, certain retirement plans, subsidized day care and others).

We have recommendations which we believe will enhance the bill. We recommend field audits and desk audits on a regular basis, in addition to a uniform reporting mechanism which could be incorporated in the facility's annual cost report. We believe the bill should clearly include wage pass through for all RNs involved in patient care, nursing administration, nursing

education and other categories of utilization within the Department of Nursing. Since part time employment is an option which is attractive to many women who are engaged in child care or elder care, we believe the community wage comparability calculations should address part time employees as well.

In keeping with the intent of this legislation, we suggest that the Committee consider additional incentives to achieve the aim of adequate numbers of well qualified nursing personnel in nursing facilities. One incentive which this Committee could explore with the Ways and Means Committee would be to allow an exception from the Social Security earnings ceiling for those employees currently drawing Social Security OASDI who also work in nursing facilities which experience difficulty in recruiting and retaining nursing personnel. We believe this simple strategy will be beneficial for nursing personnel, a work force of mostly women who typically have had a history of multiple employers, substantial breaks in employment for child and elder care, and little or no pension coverage in their employment history. Continued employment in the work force means that not only will the employees be paying taxes and accruing additional quarters of Social Security coverage, but they also may make less use of Medicare for health care, to the extent that their employer provides first payor health care coverage. We note with pleasure the special magic that happens when older employees themselves provide care to the residents of a nursing home. When that happens, there is an element of role modeling that cannot be duplicated by younger staff.

We recommend that the wage comparability provisions of the bill clearly delineate comparability based on all job titles of registered nurses. That

is, classifying all RNs into one of two categories, supervisory or staff, does not allow for a Medicaid pass through of salaries for nurses who are gerontological nurse practitioners or clinical nurse specialists, as well as staff development nurse instructors or researchers. Including those categories in the calculations could allow for pass through of competitive salary for those highly skilled individuals whose knowledge when implemented is associated with better resident outcomes and more cost-effective resource utilization.

Related to that point, we suggest that since wage compression is such a common feature of nursing facility wage scales, that the salary comparability provisions of the bill clearly delineate comparability based on years of related experience, education and demonstrated competence (such as national certification of excellence in practice), just as hospital salary scales are typically structured.

We suggest also that employers provide paid continuing education courses for pre-service and in-service education....updates on medication use, new intervention strategies with special populations, cardiopulmonary resuscitation, and so on.

In closing, we are pleased to see this approach to resolving some dilemmas in nursing facility care. We believe this is one approach which fulfills the Institute of Medicine's major recommendation:

> "....nursing homes should place their highest priority on the recruitment, retention and support of adequate numbers of professional nurses who are trained in gerontology and geriatrics, to ensure an adequate number and appropriate mix of professional and nonprofessional nursing personnel to meet the needs of all types of residents in each facility." (IOM, 1986, p. 103)

Thank you for this opportunity to address our views. We are grateful for your continuing thoughtful hard work toward the benefit of this nation's nursing facility residents.

Mr. WAXMAN. Thank you.
Ms. Sackman.

STATEMENT OF KATHY SACKMAN

Ms. SACKMAN. I am Kathy Sackman, a registered nurse in the State of California and a Vice President of the American Federation of State, County, and Municipal Employees.

As cochairperson of the United Nurses of America, I speak to you today on behalf of over 40,000 nurses and over 60,000 nurse aides represented by AFSCME.

We are particularly grateful for Representative Walgren's recognition of the crisis in nursing facility care.

AFSCME has a long and proud history of fighting for the rights of nursing home workers. In 1988, our union in conjunction with the Older Women's League published the monograph, "Chronic Care Workers: Crisis Among Paid Caregivers of the Elderly." I wish to submit a copy of that publication for the record.

Mr. WAXMAN. Without objection, it will be received for the record.

Ms. SACKMAN. That study underscores many of the critical issues this committee will consider as it examines the plight of nursing facility residents and their caregivers.

AFSCME has achieved pacesetting results for nurses and nurse aide members alike through collective bargaining. For example, in the most recent contract negotiations in my home State, the United Nurses Association of California negotiated contracts with hospital employers which introduced a unique 5/10/15 year clinical ladder system, pilot flexible schedule programs guaranteeing 5-night shifts of pay for 4-night shifts of work, and a $25 hour rate for in-house registry nurses.

Most importantly, we negotiated a 3 year wage package which included a 10 percent increase the first year with automatic raises in the second and third years pegged at a percentage of 4 percent above a 17-hospital area average. In effect, we have already implemented for hospital-based nurses what, Representative Walgren is proposing for nursing facility workers in H.R. 1649. In States like New York, Pennsylvania, and Wisconsin where AFSCME represents large numbers of nurse aides, we also have greatly improved the living and working standards of such workers.

If we could extend such achievements nationwide for nurses and nurse aides, we would. But our success in contracts around the country does not help the thousands of patients and workers across this country whose living and working conditions have not yet been improved by collective bargaining.

Unfortunately, the vast majority of nurses and nurse aides, especially those employed in nursing facilities remain woefully underpaid and overworked.

In 1985, among all nurses, the average general duty nurse in a nursing facility earned between $9.25 and $10.60 per hour, while their counterparts in a hospital setting averaged between $11.12 and $12.14 per hour, or roughly 17 percent higher.

Nurse aides are squeezed in the same economic vise. The differential between nurse aides working in nursing facilities and hospi-

tals averaged nearly 36 percent, or a difference between $4.10 and $5.04 per hour in nursing facilities and $6.38 to $7.26 in hospitals. Many nurse aides made far less than that average. In fact, typically, nearly one half of the full time aides and two thirds of the part-time aides earned less than the average.

Why is it so important that we not shortchange nursing facility care in the United States? In this country over 200,000 nurses and 500,000 nurse aides work in nursing homes, and unless we address the existing crisis among paid caregivers for the elderly and infirm, we are inviting scandals and warehousing of the elderly on an unprecedented scale.

In some parts of the country, a shortage of nurse aides is growing, even as the need for services rises. The U.S. Department of Labor has projected that the nursing facility industry will need over 425,000 new nursing aides by the year 2000. At the same time, aide employment in hospitals is expected to decrease by 60,000 positions over the same period. Therefore, over time, the nursing aide occupation is becoming a long-term care operation.

Between 1981 and 1986, average RN employment in nursing facilities increased 22 percent. Surveys completed in 1987 suggest that despite these increases nursing homes sought even greater numbers of RN's.

Shortages of nurses—both RN's and LPN's—in nursing facilities are expected to continue based on cost containment pressures relegating sicker patients to nursing facilities and on overall demand for nursing facility services.

How can we affect this growing crisis?

Unions like AFSCME, are seeking higher wage settlements as well as bargaining for innovative career/clinical ladders and work schedules as well as child care and educational benefits.

But the data are clear. Without some overall economic relief, the crisis of retaining quality chronic care workers will only deepen.

It is apparent that the current Medicaid policy of paying "reasonable and adequate" pay rates for nursing staff is not adequate to maintain a quality workforce. While we have questions regarding whether the new minimum nursing facility wage rate would be mandatory and how it would be enforced, we believe such a measure would help alleviate the 70 percent to 100 percent turnover rates among nursing aides.

Low pay is a major reason for these rates. More importantly, in these times of fiscal austerity, Congressman Walgren's area-wage concept might cost less than, or at least equal, the constant additional training and administrative costs associated with staff turnover.

We view the bill, as a first step. AFSCME is committed to organizing—through collective bargaining, community action, public education, and further research—so that subsequent steps will guarantee that nursing facility residents and their caregivers obtain the quality of life and worklife they so richly deserve.

Thank you for your attention to this crisis.

[Testimony resumes on p. 110.]

[The prepared statement and attachment of Ms. Sackman follow:]

PREPARED STATEMENT OF KATHY SACKMAN, INTERNATIONAL VICE PRESIDENT OF THE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES

Mr. Chairman, and members of the Committee, I am Kathy Sackman, a Registered Nurse in the State of California and a Vice President of the American Federation of State, County and Municipal Employees.

As cochairperson of the United Nurses of America, I speak to you today on behalf of over 40,000 nurses and over 60,000 nurse aides represented by AFSCME. We are particularly grateful for Representative Walgren's recognition of the crisis in nursing facility care.

AFSCME has a long and proud history of fighting for the rights of nursing home workers. In 1988, our union in conjunction with the Older Women's League published the monograph, "Chronic Care Workers: Crisis Among Paid Caregivers of the Elderly." (I wish to submit a copy of that publication for the record). That study underscores many of the critical issues this Committee will consider as it examines the plight of nursing facility residents and their caregivers.

AFSCME has achieved pacesetting results for nurses and nurse aide members alike through collective bargaining. For example, in the most recent contract negotiations in my home state, the United Nurses Associations of California negotiated contracts with hospital employers which introduced a unique 5/10/15 year clinical ladder system, pilot flexible schedule programs guaranteeing five night shifts of pay for four night shifts of work and a $25/hr. rate for in-house registry nurses.

Most importantly, we negotiated a three year wage package which included a 10 percent increase the first year with automatic raises in the second and third years pegged at a percentage of 4 percent above a 17-hospital area average. In effect, we have already implemented for hospital-based nurses what, Representative Walgren is proposing for nursing facility workers in H.R. 1649. In States like New York, Pennsylvania, and Wisconsin where AFSCME represents large numbers of nurse aides, we also have greatly improved the living and working standards of such workers. If we could extend such achievements nationwide for nurses and nurse aides, we would.

But our success in contracts around the country does not help the thousands of patients and workers across this country whose living and working conditions have not yet been improved by collective bargaining.

Unfortunately, the vast majority of nurses and nurses aides especially those employed in nursing facilities remain woefully underpaid and overworked.

In 1985, among all nurses, the average general duty nurse in a nursing facility earned between $9.25 and $10.60 per hour, while their counterpart in a hospital setting averaged between $11.12 and $12.14 per hour, or roughly 17 percent higher.[1]

Nurse aides are squeezed in the same economic vise. The differential between nurse aides working in nursing facilities and hospitals averaged nearly 36 percent, or a difference of between $4.10 and $5.04 per hour in nursing facilities and $6.38 to $7.26 in hospitals.[2] A survey in 1985 indicated that nurse aides working in nursing facilities on average made $182/week, or roughly $9,500/year.[3] Many nurse aides made far less than that average. In fact, typically, nearly one-half of the full time aides and two thirds of the part-time aides earned less than the average. In 1988, according to BLS data, janitors and file clerks earned more than nurse aides.

Nurse aides have also lost ground against inflation. In a study of wages in female-dominated and male-dominated occupations, the Census Bureau found that nursing aides averaged $3.98/hour in 1979, and only $3.91/hour (in 1979 dollars) by 1986.[4] Until the minimum wage was recently raised, many nurse aides received wages close to $3.35/hr. Such a hourly rate in 1987 placed an aide and her family at 80 percent of the poverty level. Why is it so important that we not shortchange nursing facility care in the U.S.? In this country over 200,000 nurses and 500,000 nurse aides work in nursing homes, and unless we address the existing crisis among paid caregivers for the elderly and infirm, we are inviting scandals and warehousing of the elderly on an unprecedented scale.

In some parts of the country, a shortage of nurse aides is growing, even as the need for services rises. A report issued this week outlines a shortage of over 18 per-

---

[1] Bureau of Labor Statistics, Industry Wage Survey: Hospitals, August, 1985 (Department of Labor, Washington, D.C.), p.2.

[2] Bureau of Labor Statistics, Industry Wage Survey: Nursing and Personal Care Facilities, September 1985 (Department of Labor, Washington, D.C. 1987), p. 2.

[3] Ibid.

[4] Male-Female Differences in Work Experience, Occupation, and Earnings: 1984, Current Population Reports, P-70, No. 10 (Census Bureau, 1987) Table 11.

cent for nurses in nursing facilities.[5] Most observers predict a far more serious worker shortage will hit nationwide over the next 15 years.

The U.S. Department of Labor has projected that the nursing facility industry will need over 425,000 new nursing aides by the year 2000.[6] At the same time, aide employment in hospitals is expected to decrease by 60,000 positions over the same period. Therefore, over time, the nursing aide occupation is gradually becoming a long term care occupation.

Between 1981 and 1986, average RN employment in nursing facilities increased 22 percent.[7] Surveys completed in 1987 suggest that despite these increases nursing homes sought even greater numbers of RNs.[8] Shortages of nurses—both RNs and LPNs—in nursing facilities are expected to continue based on cost containment pressures relegating sicker patients to nursing facilities and on overall demand for nursing facility services.

How can we affect this growing crisis?

Some providers are utilizing alternative approaches to recruit and retain staff, such as subsidizing transportation, educational benefits, and child care. Unions like AFSCME, are seeking higher wage settlements as well as bargaining for innovative career/clinical ladders and work schedules.

But the data is clear. Without some overall economic relief, the crisis of retaining quality chronic care workers will only deepen. Thus we wholeheartedly support Congressman Walgren's attempt to establish a prevailing wage rate for nursing facility workers. It is apparent that the current Medicaid policy of paying "reasonable and adequate" pay rates for nursing staff is not adequate to maintain a quality workforce. While we have questions regarding whether the new minimum nursing facility wage rate would be mandatory and how it would be enforced, we believe such a measure would help alleviate the 70 percent to 100 percent turnover rates among nursing aides.[9] Low pay is a major reason for these rates. More importantly, in these times of fiscal austerity Congressman Walgren's area-wage concept might cost less than or at least equal the constant additional training and administrative costs associated with staff turnover.

We view this bill, as a first step. AFSCME is committed to organizing—through collective bargaining, community action, public education, and further research so that subsequent steps will guarantee that nursing facility residents and their caregivers obtain the quality of life and worklife they so richly deserve.

Thank you for your attention to this crisis.

---

[5] Medicine and Health, Vol. 44, No. 16 (July 1990).

[6] Bureau of Labor Statistics, National Industry-Occupational Matrix, 1986–20 p. 524; and Projections 2000, BLS Bulletin 2302 (March 1988), p. 51.

[7] Secretary's Commission on Nursing, Final Report, Department of Health and Human Services, December, 1988, p. 3.

[8] Ibid.

[9] Institute of Medicine, Improving the Quality of Care in Nursing Homes (National Academy Press, 1986), p. 11 and p. 90.

Chronic Care Workers:
Crisis Among Paid Caregivers of the Elderly

Preface

Without affordable access to quality long term care, millions of American families will continue to face severe hardship when confronting the need for such care—the grandparent with a broken hip or Alzheimer's disease; the spouse who suffers a stroke; the worker in the prime of life disabled by an accident; the child with cerebral palsy.

According to a 1987 poll by R.L. Associates, nearly half of all Americans have faced the long term care issue in their own families and another 20 percent expect to face the issue within five years. The poll also revealed that most Americans agree that better quality care will result if government funding allowed nursing homes to pay workers higher wages. As for assistance at home, over 40 percent of those surveyed who try to get paid help at home find it difficult to get access to such services.

At a time when the need for chronic care services is increasing, there is a growing shortage of adequately trained nursing aides and home health care workers. This shortage can be directly linked to the woefully inadequate pay and fringe benefits offered these

chronic care workers and to the adverse working conditions including hours of work, understaffing, lack of training and absence of promotional opportunity.

It is chronic care workers and not doctors and nurses who provide most of the long term care, yet during public debate on health care policy they are often ignored as a key element to ensure success in providing an adequate supply of quality care. Therefore, it is in the interest of both care givers and receivers that the workers who feed, bathe and dress frail elderly and disabled individuals receive adequate pay and benefits.

Meeting the needs of those who must receive long term care requires a comprehensive solution to the problems presented in this report. In this report we document the plight of chronic care workers and include a call to action setting forth a comprehensive program to meet the needs of long term care recipients and care givers alike.

Executive Summary

Chronic care workers are health care service workers in long term care settings. They are nursing aides and home health aides who provide daily care to frail, chronically ill persons in nursing homes and at home.

Numbering about 1.5 million, these workers are nearly all women—usually middle-aged—and include a disproportionate number of minorities. They receive little or no training yet care for an increasingly sicker and disabled population.

Chronic care workers are employed by more than 25,000 nursing homes and about 12,000 home health agencies. A majority work in for-profit institutions and agencies. They earn low wages—typically at or near the minimum wage—and few if any benefits. A majority are their family's prime wage earner.

Job turnover among chronic care workers is high. Among the reasons: low pay, poor benefits, inadequate training, stressful

working conditions, few opportunities to advance, and low status in the health care hierarchy.

In some parts of the country, workers are in short supply, and demand is expected to increase: 500,000 new nursing aides and home health aides will be employed by the year 2000.

But wages for chronic care workers are not likely to increase rapidly. Providers are under growing pressure to contain costs, while at the same time to increase staffing levels of registered nurses, for which there is an even greater shortage.

As policy makers consider comprehensive long term care programs, questions of adequate staffing—with equitably compensated and well-trained caregivers—must take center stage.

Crisis Among Paid Caregivers of the Elderly

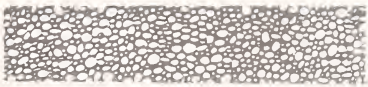
Long term care for a growing elderly population is one of the most critical aging policy issues facing the United States. Many dimensions of this issue have been or are being examined: current and projected needs, access to a broad spectrum of services, quality of care, cost and financing mechanisms.[1]

In this context, the needs of caregivers have come to public attention in recent years. Most frail and disabled older persons are not in nursing homes, but live at home, and are cared for by unpaid family members.

Studies have documented that informal caregivers are primarily women. Day after day, they help bathe, feed, dress, and toilet family members unable to do these "activities of daily living" independently. They change the sheets, clean house, prepare meals, do laundry and all the other daily tasks that make it possible for the relative to remain in the community. They make sure medicine is taken, give enemas, change dressings, and monitor health problems.

The care they give is not "free." Caregivers pay a high price—physical, emotional, and financial—for the services they provide. Policy makers and service providers are beginning to recognize and address the needs of unpaid caregivers, through respite programs, caregiver support groups, adult day care, information and referral programs.[2]

But little attention has been focused on *paid* caregivers who provide the same daily services. In low-wage jobs giving care deemed "custodial," they are the backbone of the nursing home and home health care industry. These caregivers too are overwhelmingly



women. They do the same labor-intensive, demanding work as unpaid caregivers, but they do it for (initially) strangers, not family members. They work in the same settings as health care professionals, with none of the recognition or status, and substantially fewer benefits and lower wages.

The focus of this paper is "chronic care workers": persons who are paid to provide daily care to frail, chronically-ill and incapacitated individuals, most of whom are elderly. They are health-care service workers in long-term care settings—in nursing homes and related facilities, and in private homes.[3]

Their job titles vary. In nursing homes, they are nursing aides. (The older title, "nurse's aide," is singularly inappropriate in this setting, since very few nurses are involved in the daily care of residents). It is estimated that nursing aides provide up to 90% of patient care in nursing homes.[4]

In private homes, they may be called by scores of different titles; "home health aide" is used here. Although there are very distinct differences in working conditions between those who provide care in the home and those who work in nursing homes, their role and status as chronic care workers justifies a joint examination.

What follows is, first, a summary of current national data about nursing home aides and home health aides. The discussion includes, to the extent available, information about the numbers of these workers, who they are, where they work, and their hours, wages, benefits, and training.

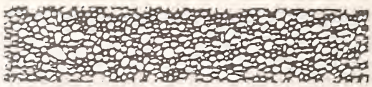
The second part of the paper reviews key elements contributing to a growing crisis among paid caregivers of the elderly: current shortages of workers, to which high turnover contributes; projected demand for workers over the next 15 years; and the impact of recent public policy changes, including legislation setting minimum standards for training.

Appended is a chronic care workers bill of rights and a call to action for advocates concerned about equity for workers in health service occupations and about quality long term care for the nation's elderly.

Nursing Homes

In 1986, there were 25,600 nursing and related care homes in the United States, with a total of 1,709,000 beds.[5] Nursing homes are generally grouped by ownership, size, and type of certification/licensure, as shown in Table 1.

Included among these facilities are all nursing homes certified



for participation in Medicare/Medicaid (8,045 skilled nursing facilities [SNFs] and 5,375 intermediate care facilities [ICFs]), as well as 2,968 uncertified homes that are licensed or provide nursing care.

All other homes are classified as "residential facilities." The latter, though numerous, are small facilities (such as board and care homes, personal care homes, and homes for the aged). They have substantially fewer beds and lower occupancy rates than nursing homes.

TABLE 1—Nursing & Related Care Homes in 1986, by Selected Characteristics

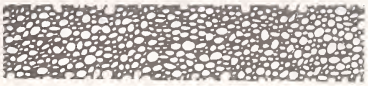
	HOMES		BEDS		Average
	Number	% of Total	Number	% of Total	Bed Size
ALL HOMES	25,646	100%	1,709,000	100%	67
NURSING HOMES	[16,388]	[64%]	[1,507,000]	[88%]	[92]
for-profit	12,336	48%	1,079,000	63%	87
non-profit	3,263	13%	329,000	19%	101
government	789	3%	100,000	6%	126
RESIDENTIAL FACILITIES	[9,258]	[36%]	[202,000]	[12%]	[22]
for-profit	7,887	31%	156,000	9%	20
non-profit	1,115	4%	39,000	2%	35
government	256	1%	7,000	.5%	27

Source: National Center for Health Statistics, *Advance Data* No. 147, Tables 3-4.

The vast majority (88%) of the 1.7 million available beds are in nursing homes. Most nursing homes (75%) are for-profit businesses; these nursing homes operate nearly 72% of all nursing home beds.

The total number of residents—as distinct from beds—in these facilities was 1,553,000 in 1986; persons over age 65 accounted for 90% of those residing in nursing homes.

In 1985 (the most recent year for which data is available), nursing and related care homes employed the equivalent of 1.2 million full-time employees [FTE]. (Thirty-five hours of part-time work is considered to be one FTE). Nursing aides were the largest group providing nursing care (500,000 FTE), and constituted 43% of all FTE staff.[6]



For every 100 beds, on average the facilities employed the equivalent of 31 nursing aides, 7 licensed practical nurses, and 5 registered nurses. Residents are there around the clock, however, while FTE staff figures are based on 35 hour weeks. These figures translate to an average of about 6.5 aides, 1.5 LPNs and 1 RN for every 100 beds.[7] In practice, there are fewer staff on the night shifts and more on the day shifts.

TABLE 2—Full-Time Equivalent Employees in Nursing and Related Homes, 1985

	Number	% of Total	Rate per 100 Beds
TOTAL FTE STAFF	1,160,000	100%	71.4
Administrative, medical, therapeutic	89,000	8%	5.5
Nursing			
RN	83,000	7%	5.1
LPN	120,000	10%	7.4
Aides	501,000	43%	30.8
All other staff	366,000	32%	22.5

Source: National Center for Health Statistics, *Advance Data*, No. 131, Table 5.

Two-thirds of all FTE aides/orderlies were in for-profit homes; nearly all (93%) were in Medicare/Medicaid certified homes. The number of FTE nursing aides/orderlies per 100 beds varied with the type and location of the nursing home. The rate was highest in skilled nursing facilities, in government operated homes, and in the West; it was lowest in uncertified homes, for-profit institutions, those with fewer than 50 beds, and in the South.[8]

Nursing Aides

The staffing patterns described above denote full-time equivalent positions, not the numbers of persons filling them. According to the Department of Labor, in 1986 there were 1.2 million individuals working as "nursing aides, orderlies and attendants."[9] This figure includes only those working in wage or salary jobs, and does not include an unknown number of self-employed aides.

The number of aides employed by various agencies is shown in

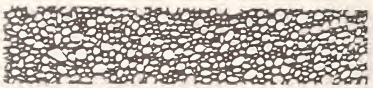


TABLE 3—Number and Rate of FTE Nursing Aides in 1985, by Type of Home

	FTE Nursing Aides/ Orderlies		
	Number	% of Total	Rate per 100 Beds
Total FTE Aides	501,000	100%	30.8
Ownership			
for-profit	332,000	66%	29.6
non-profit	122,000	24%	32.8
government	47,000	9%	35.7
Certification			
SNF only	106,000	21%	34.5
SNF and ICF	240,000	48%	33.1
ICF only	119,000	24%	29.2
not certified	36,000	7%	19.4
Number of beds			
fewer than 50	36,000	7%	23.5
50-99	141,000	28%	31.8
100-199	219,000	44%	31.1
200+	106,000	21%	32.4
Region			
Northeast	113,000	23%	30.5
North Central	168,000	33%	31.6
South	145,000	29%	29.6
West	76,000	15%	32.5

Source: National Center for Health Statistics, *Advance Data* No. 131. Table 5.

TABLE 4—Employment of Nursing Aides, Orderlies and Attendants

	# of persons	% of total
Total Aides/orderlies/attendants	1,205,000	100.0%
Nursing and personal care facilities	530,000	44.0%
Hospitals	368,000	30.5%
Government	93,000	7.7%
Private households	73,000	6.1%
Social services—residential care	47,000	3.9%
Business services—personnel supply	43,000	3.6%
Health services-miscellaneous	16,000	1.4%
Social services-miscellaneous	9,000	.7%
Education	11,000	.9%
Other	15,000	1.2%

Source: Bureau of Labor Statistics, "National Industry-Occupational Matrix, 1986-20," p. 524.

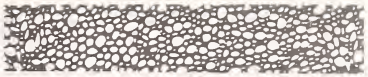


Table 4. About half of all nursing aides worked in nursing homes (44% plus some portion of those working for "government" and for "business services-personnel supply"—i.e., temporary agencies).

Nursing aides are overwhelmingly women (90%) and very disproportionately minorities (31% Black and 7% Hispanic). In contrast, in 1987 the labor force as a whole was 45% female, 10% Black, and 7% Hispanic. During the past ten years, the number and proportion of women, Blacks and Hispanics who work as nursing aides have grown steadily.[10]

TABLE 5—Nursing Aides, Orderlies, Attendants
Selected Characteristics, 1977-1987

Year	Number Employed	WOMEN	BLACK	HISPANIC
1987	1,324,000	90.4%	30.8%	6.6%
1986	1,299,000	90.5%	29.5	5.0%
1985	1,242,000	89.9%	29.2	4.9%
1984	1,235,000	90.4%	29.0	4.9%
1983	1,269,000	88.7%	27.3	4.7%
1982	1,136,000	87.1%	31.3%**	
1981	1,116,000	86.6%	28.3%	
1980	1,093,000	87.5%	28.8%	
1979	1,024,000	87.5%	30.6%	
1978	1,037,000	87.0%	27.6%	
1977	1,008,000	86.3%	26.5%	

**designated "Black and other" through 1982

Source: *Employment and Earnings* Vols. 25-35 (1978-1988), "Employed Persons by Detailed Occupation, Sex and Race," Annual Averages.

On a national basis, very little up-to-date demographic information is available on nursing aides who work in nursing homes. While the 1985 National Nursing Home Survey collected detailed information about registered nurses who staff nursing homes, similar questions about aides were dropped from the draft questionnaire.[11]

Information about nursing aides was collected in the 1977 National Nursing Home Survey. At that time, there were 345,000 full-time and 118,000 part-time aides working in nursing homes. About 5% of both groups were contract workers.

As a group, they were 93% female; 72% were white, 21% Black, 2% Hispanic, and 4% other races. Their average age was 34 years. One third had less than 12 years of education; 44% had exactly 12 years; 21% had more than 12 years.

Full-time workers averaged 5.2 years of employment experience

as nursing aides, with an average of 3.2 years on the current job. Part-time aides had an average of 4.8 years total nursing aide experience.[12]

Nursing Aide Wages and Benefits

In a Bureau of Labor Statistics study of nursing home workers in 22 metropolitan areas, the typical hourly wage for a full-time nursing aide was between $4.00 and $5.00 per hour in September, 1985. Part-time aides earned less.

The average hourly rate for full-time nursing aides ranged from a low of $3.65/hour in Houston to a high of $8.87/hour in New York City. Table 6 ranks the 22 cities in order of hourly wage.[13]

These wage figures constitute the *average* for the location; many aides earn less. Typically, nearly one-half of the full-time aides and two-thirds of the part-time aides earned less than the average. Outside metropolitan areas, wages are lower, often hovering around the minimum wage. In general, hourly wages were higher in cities where a greater proportion of workers were union members and/or where a greater proportion of part-time aides worked.

Medicaid reimbursement policies are also a strong determinant of nursing home worker wages. Medicaid pays for almost half the total cost of nursing home care in the U.S. and reimbursement rates vary from state to state. For example, state Medicaid rates for care in a skilled nursing facility in 1986 ranged from a low of $32/day in Arkansas to over $150/day in Alaska.[14] Because labor costs are 75% of total costs, wages are closely linked to these figures.

In most cities surveyed, three out of four full-time employees worked in a nursing home that offered sick leave benefits and major medical coverage; fewer than one in four was in a nursing home that had a pension plan. But this data should *not* be interpreted to mean employees received the benefits, or that they were provided at no charge. The study did not probe eligibility requirements, cost-sharing, and other issues that affect how many and which employees actually receive benefits. For example, pension plans can legally exclude categories of full-time workers and can require 10 years of work (5 years after Jan. 1989) before guaranteeing the right to a pension. Few nursing aides qualify.

The 1977 National Nursing Home Survey collected benefit information specific to nursing aides which may be useful for comparison. Among full-time aides, 80% had sick leave and paid vacations,

TABLE 6—Average Hourly Wages of Full-Time Nursing Aides in Nursing Homes, 1985

SITE	AVERAGE HOURLY WAGE*	% of PART-TIME AIDES	% OF NONPROFESSIONAL WORKERS			
			under contract #	in facilities that offer sick leave +	major medical +	pension coverage +
Houston	$3.65	10%	5-9%	64%	53%	12%
Dallas	$3.85	9	0	40	73	11
Atlanta	$3.85	14	15-19	83	93	23
Detroit	$4.01	25	55-59	78	34	14
St. Louis	$4.08	20	20-25	71	78	30
Kansas City	$4.10	20	10-14	81	61	13
Denver	$4.19	22	5-9	47	50	4
Chicago	$4.43	20	65-69	94	49	6
Los Angeles	$4.51	14	5-9	80	55	5
Cleveland	$4.52	30	45-49	85	86	31
Baltimore	$4.56	34	25-29	90	98	23
Seattle	$4.68	37	5-9	78	91	5
Washington, DC	$4.68	29	20-24	94	100	21
Miami	$4.70	6	40-44	100	55	28
Buffalo	$4.77	42	55-59	100	84	75
Philadelphia	$4.98	35	45-49	95	93	48
Milwaukee	$5.04	54	25-29	88	97	57
San Francisco	$5.21	23	65-69	97	78	18
Oakland	$5.30	23	50-54	94	36	2
Boston	$5.36	42	5-9	87	94	22
Minn./St. Paul	$6.37	64	35-39	96	95	32
New York City	$8.87	23	90-94	100	98	91

* excludes any premiums paid for overtime, weekends, late shifts

\# proportion of non-professional employees in facilities where the majority are covered by a labor-management agreement

\+ proportion of non-professional employees in facilities where the benefit is offered (not necessarily to all employees and not necessarily employer-paid)

Source: BLS, *Industry Wage Survey: Nursing and Personal Care Facilities* (1987), Tables 2-45 and 49.

46% had health insurance, and 19% had pension coverage. But few part-time workers had these benefits; 15% got vacation/sick leave, 6% had health insurance, and 2% were covered by a pension.[15]

A private national survey of about 1300 nursing homes showed that the median hourly wage of "not certified" nursing aides is now less than the wage paid to food service, housekeeper and laundry aides who work in nursing homes.[16] (Most nursing aides are not certified; few states now have any training requirements). As shown in Table 7, between 1983 and 1988, the hourly pay of most nursing aides increased from $3.35 to $4.32 (after inflation, 2.5% each year); they actually earned *less* per hour in 1988 than in 1986.

TABLE 7—Median Hourly Wage of Selected Nursing Home Workers, 1983-1988

	1983	1984	1985	1986	1987	1988
Nursing Aide (certified)	$3.89	4.27	4.37	4.58	4.80	5.01
Nursing Aide (not certified)	3.35	3.97	3.94	4.42	4.56	4.32
Housekeeping/laundry aide	3.50	4.08	3.84	4.50	4.71	4.70
Food Service Aide	3.95	3.99	4.10	4.35	4.51	4.45

Source: *1988 Nursing Home Salary and Benefits Report* (Hospital Compensation Service, February 1988), ix.

Whether or not the median hourly wage of nursing aides nationwide has dropped in the past two years, wages have clearly not kept pace in recent years. First, Department of Labor data indicates that wage increases in the nursing home industry have not kept up with service industries as a whole. Across all jobs in nursing homes, full-time pay rose from 3% to 6% annually between May, 1981 and September, 1985; during the same period, wages in the entire service sector increased an average of 7% each year.[17]

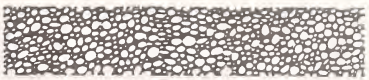
Second, within the nursing home industry, nursing aides have lost ground against inflation. In a study of wages in female-dominated and male-dominated occupations, the Census Bureau found that nursing aides averaged $3.98/hour in 1979, and only $3.91/hour (in 1979 dollars) by 1986.[18] (In general, they hypothesized and found that working in an occupation with a high proportion of women has a negative effect on earnings).

Finally, these studies use *average* hourly wages. A very significant portion of nursing aides earn less. Thousands earn the minimum wage, which has been set at $3.35 since 1981. Full-time work at minimum wage in 1981 yielded an income at the poverty level for a family of three; by 1987, the full-time aide working at minimum wage and her family had fallen to 80% of the poverty level.[19]

Home Health Agencies

Home health agencies provide or broker services ranging from high technology medical care—such as home dialysis, chemotherapy, and tube feeding—to daily personal care, food preparation and other household assistance that enable a frail or ill person to live at home.

The home health care industry is complex and diverse, charac-



terized by rapid recent growth, increased corporatization, uneven government regulation, and fragmented funding and service delivery mechanisms. Home care has aptly been described "a 'black box' the workings of which are largely a mystery."[20]

In 1988, there are between 11,000 and 12,000 home health agencies in the United States.[21] Only about half of them have been certified for reimbursement under Medicare/Medicaid. The remainder are licensed and/or regulated in varying degrees by state governments in 35 states.[22]

The Public Health Service has not collected data on home health care that is comparable to its National Long Term Care Survey for institutional care. And only in 1987 was home health care included as an industry under the Standard Industry Classification system by the Bureau of Labor Statistics.

It is possible, therefore, to describe only the Medicare-certified agencies. Prior to 1980, the federal government did not certify for-profit agencies in states that had no licensing laws (about half didn't). Most home health service providers were either government agencies or the traditional Visiting Nurse Associations. But when legislative changes permitted the certification of for-profits regardless of state licensure, their numbers increased rapidly.

The number of these Medicare-certified agencies by type for selected years since 1967 is shown in Table 8. Certified for-profit agencies have increased 600% since 1981; certified agencies have doubled since 1980.[23]

TABLE 8—Medicare-Certified Home Health Agencies, 1967-1987, by Type[24]

	March 1967	July 1981	July 1984	Dec. 1985	Dec. 1987	change 1967-87
Agency Type						
Visiting Nurse Assn.*	642	570	580	573	551	−91
Government	939	1,241	1,231	1,205	1,073	+134
Hospital-based**	133	429	691	1,277	1,439	+1,306
For-profit	0	262	1,255	1,943	1,846	+1,846
Private non-profit	0	551	719	843	766	+766
Other #	39	57	208	153	110	+71
TOTAL	1,753	3,110	4,684	5,983	5,785	+4,032

*Includes combined VNA/Health Dept.
**Includes an unknown number of for-profit agencies
#those based in rehabilitation agencies and skilled nursing facilities

Unlike the nursing home industry, where the numerous noncertified and unlicensed facilities serve only a small portion of the

total number of residents in nursing homes and related facilities, noncertified home health agencies deliver services in proportion to their numbers. About half of these services are provided by noncertified agencies.

Home Health Agency Staffing Patterns

Without the kind of data provided by Public Health Service national surveys or Department of Labor industry surveys, there is little nationwide information on agency staffing patterns.

Using data from annual surveys of Medicare-certified agencies made by the Health Care Financing Administration, the industry trade association has estimated full-time staff equivalents. Data on salaried staff was taken directly from the surveys, but data on contract staff was based on salaried/contract worker ratios from 1982, and is probably considerably underestimated.[25]

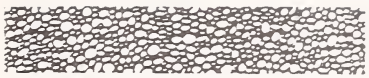
TABLE 9—Salaried and Contract FTE Staff in Certified Home Health Agencies, 1986

	Salaried	Estimated Contract	Total	% of Total
TOTAL FTE Staff	105,000	25,600	130,600	100%
Registered nurses	39,500	1,700	41,200	32%
Licensed practical nurses	3,800	200	4,000	3%
Physical therapists	6,200	7,900	14,100	11%
Occupational therapists	2,000	1,800	3,800	3%
Speech therapists	3,100	6,200	9,300	7%
Aides	26,300	7,300	33,600	26%
Other	24,000	500	24,500	19%

Since certified agencies are more likely than noncertified agencies to deliver care provided by RNs and other professionals, the latter undoubtedly have a higher proportion of home health aide FTE staff. Virtually no data about noncertified agencies is collected on a national basis, however.

Home Health Aides

With little comprehensive data available on home health agencies, it is not surprising that information about their non-



professional employees is sparse at best. But the reason is not only that the industry as a whole has experienced rapid growth, is unevenly regulated, and is fragmented among various agency bases and funding sources. The problem is also the lack of a single commonly accepted occupational title to name these chronic care workers who work in the homes of individuals.

Scores of titles have been used to describe the work they do. Some examples include: homemaker-home health aide, home care worker, homemaker, home health aide, personal care worker, home attendant, home helper, chore worker, family care worker, companion, home nursing assistant, independent provider/ contractor, home help support worker.[26]

Confusion about job titles is also fostered by varied funding mechanisms. As one VNA director explained,

> The home health aide of the Medicare program is essentially doing the same tasks as the homemaker of the Title XX programs, and the same tasks as the personal care aide of the Medicaid program, and the same tasks as the home aide in some programs for the aging.[27]

The 1980 Census identified 292,000 "health aides." However, these persons constituted a residual category of all health personnel below the technical level (with nursing aides and dental assistants subtracted), unrelated to any specific health occupation.[28]

The Bureau of Labor Statistics collects data on the occupation "home health aide" (the same as "homemaker-home health aide" in the *Occupational Outlook Handbook*). In 1986, there were 138,000 persons in this job category.[29] But local studies of home care workers seem to indicate that this national figure substantially underestimates the number of persons actually performing the functions of home health aides.

A union contract was recently negotiated on behalf of about 50,000 home care workers in New York City; another 40,000 workers in the In-home Supportive Services Program in Los Angeles County are organizing.[30] Obviously these two jurisdictions do not account for more than half of home health aides in the country.

Using information from a survey of state "individual provider" programs and unpublished BLS data, one researcher estimated that there were at least 300,000 home health aides in the United States.[31]

Profile of Home Health Aides

In the absence of national demographic and wage/benefit data, research is beginning to document on a city or county basis what is known anecdotally about home health aides. For example, the majority of home health aides interviewed in a non-random sample in New York City were:[32]

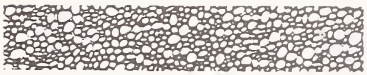
- women (99%); Black (70%) and Hispanic (26%); foreign-born (46%)
- single, *i.e.*, widowed, divorced, or never married (64%)
- middle-aged (average age was 47)
- not high school graduates (64%)
- working for less than $11,000 per year (90%); median family income was $8,000
- primary support of family (74%); had children living at home (65%)
- without health insurance (32%) or with only minimal coverage (68%)
- having difficulty in paying bills and making ends meet (85%)

In a 1987 survey of home health agencies in five metropolitan areas (Boston, Milwaukee, New York City, San Diego and Syracuse), researchers generated the same general profile.

Home health aides at the sites studied: were more than 95% female; average age, 45; 57% single and 60% primary providers; very disproportionately Black (from 15% in Milwaukee to 91% in Brooklyn) and Hispanic (up to 39%, in San Diego); average schooling, 11.7 years; average wages, $4.41 per hour. Over 75% earned less than $10,000 annually; few had employer-provided health insurance.[33] Similarly, homecare workers in Los Angeles are predominantly Black and Hispanic women, middle-aged and older, who are all paid $3.72/hour, and receive no health insurance, pension benefits, sick leave or vacation time.[34]

The general description of home health aides as overwhelmingly middle-aged women, who are not necessarily high school graduates, and who generally work part-time rather than full-time was sketched in a 1977 study of aides by the Administration on Aging.[35] But information on racial/ethnic origins and on wages or benefits was not included in the report.

The National Association for Home Care and its National Homecaring Council and Foundation for Hospice and Homecare is a final possible source of data on wages and benefits. However, NAHC



conducts only executive compensation surveys. But an article in a recent issue of its journal states that the average starting wage in the industry now ranges between $4.00 and $4.25 per hour.[36]

Growing Crisis Among Chronic Care Workers

The best data currently available confirms the image of chronic care workers as midlife women, disproportionately minorities, who work for low wages and few benefits. In some parts of the country, a shortage of workers is growing, even as the need for services increases. This section explores a set of issues related to the growing crisis among workers; they include problems associated with the recruitment and retention of workers and with policy changes affecting the nursing home and home care industries.

A) Recruitment and Retention

Given the low wages and benefits, it is not surprising that chronic care workers change jobs or leave the field entirely. Among nursing home workers, nursing aides have the highest turnover rates, ranging from 70% to 100% a year; it is not uncommon for half the aides to leave their jobs within the first six months.[37] On average the turnover rate is 60% for "paraprofessionals" who work in home care; 80% to 90% leave within two years.[38]

There are many reasons why chronic care workers are difficult to recruit and retain. The most frequently cited include:

- low wages, few benefits; for workers in the home, lack of a guaranteed income (*i.e.*, guaranteed number of hours)
- inadequate training, orientation and supervision
- no pay for classroom training
- no upward mobility, few and small wage increases
- stressful working conditions, with no pay adjustments for particularly difficult patients/families and, for home health aides in some urban areas, dangerous neighborhoods and substandard housing
- no allowance for uniforms or for travel between and with patients
- treatment as "second class" employees by the agency or institution
- in some geographical areas, low unemployment and competition from other jobs that offer better pay, benefits and work schedule, with less worker stress

Training is cited as a problem: by chronic care workers, who feel they are not adequately trained or are stressed because they must train others; by consumer advocates, who see training as a critical element in the provision of quality care in nursing homes and at home; and by providers, who must constantly deal with recruitment, training and the costs associated with worker turnover.

Unfortunately for everyone, training is all too frequently a hit or miss operation. More than thirty states have *no* requirement for the number of hours of training required for nursing aides in nursing homes; the rest have requirements varying from 19 hours (Texas) to 150 hours (California).[39] As of 1986, only 13 of the 34 states with home health licensure laws had any stated requirements for the duration and content of home health aide training.[40] Studies of how training works in practice are illuminating. In a 1987 study of nursing homes in Texas using personal interviews with nursing aides, the researcher found that most aides had *no* preparation for their work besides on-the-job training. Many of the nursing aides "reported that they began working the same day they were interviewed and that their orientation consisted of following another aide." This "buddy system" was the most commonly used method of orientation, and created conflicts for experienced aides who felt that the responsibility to train other aides contributed to patient neglect.[41]

B) Shortages of Chronic Care Workers

Throughout the country, acute and long-term health care providers have felt the impact of a shortage of nurses that is critical in many places.[42] Less attention has been directed to a similar shortage of non-licensed personnel.

Chronic care workers are in extremely short supply today in some areas, most notably in northeastern states (such as Massachusetts) and in the west. But the experience of these geographical areas portend a worker shortage that will hit the entire country over the next 15 years.

The Department of Labor projects an increase of 425,000 *new* nursing aides by the year 2000, as detailed in Table 10. If demand is particularly high, 467,000 persons will work as nursing aides, or 38% more than at present. More than 90% of these new aides will be needed in nursing homes. At the same time, aide employment in hospitals will *drop* by 60,000 over the next 15 years.[43] Thus the occupation "nursing aide" is becoming a long term care occupation.

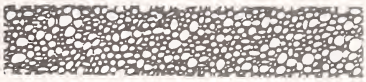


TABLE 10—Projected Employment of Nursing Aides, 2000

	1986		2000	
SITE	Number	% of Total	Number	% of Total
nursing homes	530,000	44%	917,000	56%
hospitals	368,000	32%	306,000	19%
government	93,000	8%	108,000	7%
private households	73,000	6%	77,000	5%
residential care	47,000	4%	77,000	5%
personnel agencies	43,000	4%	59,000	4%
other	51,000	4%	85,000	5%
TOTAL	1,205,000	100%	1,629,000	100%

(Source: BLS, *National Industry-Occupational Matrix, 1986-2000*, p. 524)

The Department of Labor projects that home health aide jobs will increase even more than nursing aide positions, rating it among the fastest growing occupations during the next 15 years. By the year 2000, DOL estimates 110,000 new home health aide jobs—a growth rate of 80%.[44]

Where will these new workers come from? The trade associations for nursing home and home health providers have recently surveyed their members concerning current personnel shortages. The American Health Care Association reported that more than half of responding nursing homes are having a severe (24%) or moderate (30%) shortage of nursing aides in 1987. Similarly, the National Association for Home Care found that half of responding home care providers have difficulty recruiting and retaining home health aides.[45] The lack of available home care staff was one issue raised by opponents of the Long Term Home Care bill when it was defeated in the House of Representatives in June.[46]

In the face of shortages, a few providers are trying varied approaches to recruit and keep staff, such as subsidizing transportation and child care or developing career ladders enhanced with education benefits. Others are tapping participants in welfare-to-work training programs.

A task force on home health aide shortages in Massachusetts—one of the hardest hit states—concluded that a "significant increase in the hourly rate" was needed to attract new workers.[47] How many providers are facing the essential problem of low wages and inadequate benefits is not known. Indeed, some providers are finding creative ways to trade off wages against benefits. One com-

pany with nursing homes in four southern states offers staff the "handy option" of salary increases for every benefit they choose to forego.[48]

Legislation requiring increases in the minimum wage has been opposed by the American Health Care Association but supported by some nursing home chains that believe Medicaid rates will be raised to cover wage increases. AHCA, which says that the industry "employs a high number of minimum wage workers," advocates that states be required to increase Medicaid reimbursement rates to reflect increased labor costs if the minimum wage is increased.[49]

Both nursing homes and home health agencies are turning to temporary agencies to supply them with workers. Accepted by the industry in the past for their "relatively minor and useful role," these nursing pools are now seen as competitors that adversely affect the cost and quality of care. A Florida study found that the rates the temp agencies charged for pool workers were double the wages and benefits that nursing homes paid to their regular staff. (How much the temp agency paid its pool workers is not known). AHCA now advocates the increased regulation of nursing pools and the rates they can charge.[50]

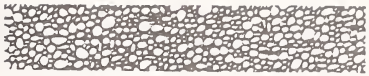
C) Public Policy Changes

Key changes in public policy are also significant factors in the crisis among chronic care workers. At the top of the list are the cost control efforts of the past five years, and recently enacted legislation to promote quality in nursing home and home health care.

- Cost Containment

The introduction of the prospective payment system under Medicare—in which hospitals are reimbursed by patient diagnosis rather than for services provided—has had a major impact on chronic care workers. One immediate effect was to make it financially advantageous for hospitals to establish home care programs; there was a marked increase in such agencies after the institution of the prospective payment system.[51] Hospitals also had an incentive to discharge patients as soon as possible. Subsequently both nursing homes and home health agencies reported sicker, more disabled patients.

For example, a survey of Medicare home health agencies by the National Association for Home Care found that a majority said they were serving increased numbers of sicker patients. At the same time, they faced increased denials of payment as a result of HCFA attempts to restrict eligiblity.[52]



States have also instituted cost-containment measures under Medicaid, which pays for almost half the total costs of nursing home care in the U.S. each year. By changing reimbursement formulas, states have cut payments and have greatly limited annual increases; 2% increases are common, and some providers have received no increases from year to year. With labor constituting nearly 75% of total costs, staffing levels and worker wages and benefits are hit hardest by these restrictions.

For chronic care workers, the results have been increased workloads, low wage increases, pressure for greater productivity, and in the case of home care workers, the fallout from uncertainty over Medicare reimbursement.

- Quality of Care

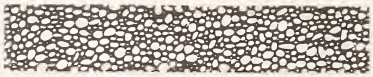
In 1987, Congress enacted nursing home reform legislation (included in PL 100-203). One provision eliminates the distinction between skilled nursing facilities and intermediate care facilities. An important difference between these designations concerns minimum staffing requirements. Skilled nursing facilities must have an RN Director of Nursing, one RN on the day shift and one licensed nurse (RN or LPN/LVN) on other shifts; intermediate care facilities must have an RN consultant 4 hrs/week, and one licensed nurse (RN or LPN/LVN) on the day shift. In 1986, fully half of the facilities certified by the federal government did not meet the SNF staffing standards.[53] As of October, 1990, all nursing homes participating in either Medicare or Medicaid must meet them.

Thousands of nursing homes will need to hire new licensed personnel at the very time when a growing shortage of nurses is creating intense competition for their services.[54] First priority for improvements in wages and benefits is thus likely to be directed to RNs and LPNs over the next few years.

A second key provision establishes training standards for new nursing aides, who must have a minimum of 75 hours of training during the first four months of employment, after which they must be able to demonstrate competency.

As the training standard is implemented, it may benefit many aides through upgraded training that can support a career ladder, but screen out others who have difficulty with written tests or who need English language or basic literacy as a requisite for classroom training.

As originally enacted, Congress singled out nursing aides as the only group of nursing home employees to be listed in new state registries of persons who had abused or neglected patients. The



registry has now been recast in positive terms as a listing of certified aides, and requires that *all* workers guilty of abuse or neglect be reported to the appropriate Board or registry.[55]

Conclusion

Chronic care workers must care for a growing number of increasingly disabled and dependent persons. They are working for agencies and institutions under growing pressure to increase productivity. They face new training and competency requirements. And most work for low wages and few benefits, which is unlikely to change soon.

Those are the elements of the crisis, which is real and will only get worse. The burdens of cost containment cannot be borne largely by an exploited female workforce. As comprehensive long term care programs are debated, questions of financing and reimbursement are not the only issues. Service delivery is a central issue: who will provide daily care? how will they be recruited, trained, retained? That will require the development of a new model of care.

Nursing aides and home health aides are oppressed by the acute medical model that still dominates long-term care services, as the "skilled" and "custodial" categories of care spawned by Medicare lock them into underclass status.

What constitutes "skilled" care? In what sense are nursing aides and home health aides *NOT* skilled workers? Are they workers without skills?

Chronic care workers aren't the only ones who ask these questions. An RN cites the nursing home patient who observed, "If you stick a [feeding] tube down someone's nose, that's skilled care; if you feed him and plead with him and coax him to eat, which takes ten times as long, that's not skilled."[56]

Or is the real issue the disdain in which caregiving and nurturing is held? Since "anyone can do it" is the general perception and those who do are nearly all women, the work is not truly valued. In contemporary American society, that means it is not valued economically; low compensation is the norm.[57]

Chronic care workers and their advocates are responding to these pressures by organizing—through union activities, research, public education, and community projects—to insure both the quality of chronic care and the quality of worklife for paid caregivers.

Notes

1. For example, Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (National Academy Press, 1986); U.S. Senate Committee on Aging, "The Long-Term Care Challenge," *Developments in Aging: 1987*, Volume 3 (1988) and "Home Care at the Cross-roads," (April 1988); Alice M. Rivlin and Joshua M. Weiner, *Caring for the Disabled Elderly: Who Will Pay?* (Brookings Institution, Washington, 1988).

2. Robyn Stone, Gail Lee Cafferata and Judith Sangl, "Caregivers of the Frail Elderly: A National Profile (National Center for Health Services Research, 1986); House Select Committee on Aging, "Exploding the Myths: Caregiving in America," (1987); Tish Sommers and Laurie Shields, *Women Take Care: The Consequences of Caregiving in Today's Society* (Triad, 1987).

3. The elderly are not the only persons who require chronic care, and there are other "nonprofessional" workers in low-wage jobs supporting its delivery; nevertheless, this paper focuses on workers who actually do the hands-on daily care of the majority who receive paid services.

4. See note 1, Institute of Medicine, p. 52.

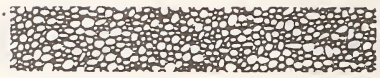
5. National Center for Health Statistics, Al Sirrocco, "Nursing and Related Care Homes as Reported from the 1986 Inventory of Long-Term Care Places," *Advance Data from Vital and Health Statistics* No. 147, January 22, 1988 (Public Health Service, Hyattsville, MD). These figures do not include 734 hospital-based facilities, with 61,0 beds, nor do they include facilities primarily for the mentally retarded.

6. National Center for Health Statistics, Genevieve Strahan, "Nursing Home Characteristics: Preliminary Data from the 1985 National Nursing Home Survey," *Advance Data from Vital and Health Statistics* No. 131, March 27, 1987 (Public Health Service, Hyattsville, MD).

7. Bruce Vladek points out the need to use three shifts when interpreting FTEs in *Unloving Care: The Nursing Home Tragedy* (Basic Books, 1980), p. 19.

8. See note 6.

9. Bureau of Labor Statistics, *National Industry-Occupational Matrix, 1986-2000* (Department of Labor, Washington, DC, 1986), p. 524.



10. "Employed Persons by Detailed Occupation, Sex and Race," Annual Averages, *Employment and Earnings* Vols. 25-35 (January 1978-1988).

11. May, 1988 conversation with BLS staff member, who stated that the Office of Management and Budget removed the proposed questions dealing with nursing aides. OMB did allow data collection about RNs, including demographic, educational, employment and facility information. For results, see National Center for Health Statistics, Genevieve Strahan, "Characteristics of Registered Nurses in Nursing Homes: Preliminary Data from the 1985 National Nursing Home Survey," *Advance Data from Vital and Health Statistics* No. 152, April 14, 1988 (Public Health Service, Hyattsville, MD).

12. National Center for Health Statistics, Al Sirrocco, "Employees in Nursing Homes in the United States: 1977 National Nursing Home Survey," *Vital and Health Statistics* Series 14, No. 25, February 1981, pp. 7-8 and Table 6.

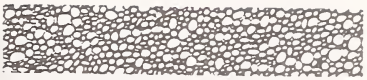
13. Bureau of Labor Statistics, *Industry Wage Survey: Nursing and Personal Care Facilities, September 1985*, BLS Bulletin 2275, March 1987 (Department of Labor, Washington, DC). Nursing homes operated by federal, state, or local governments or by hospitals were excluded from the survey.

14. James H. Swan, Charlene Harrington, and Leslie A. Grant, "State Medicaid Reimbursement for Nursing Homes, 1978-86," *Health Care Financing Review* 9 (Spring 1988), p. 44; and Robert J. Buchanan, "Medicaid Reimbursement of Long-Term Care: A Survey of 1986 State Policies," *Journal of Long-Term Home Care Administration* 15 (Winter 1987), p. 22.

15. See note 12.

16. Hospital Compensation Service, *1988 Nursing Home Salary and Benefits Report*, (John Zabka Associates, Oakland, NJ), February 1988. The report gives little detailed information about the survey or respondents.

    On the issue of aide certification: In 21 states, a nursing aide working in a nursing home receives a certificate after successfully completing a training course. In most of these states, the trainer issues the certificate, and the period of certification is limitless. In 5 states, a state agency issues the certificate; 11 states keep a registry of these certified aides. Sarah Greene Burger, *State Nurse Aide Training Survey Results* (National Citizens' Coalition for Nursing Home Reform, December 15, 1987), pp. 26-27.



17. "Occupational Pay Structure in Nursing and Personal Care Facilities, *Monthly Labor Review* 34 (July 1987), p. 41.

18. *Male-Female Differences in Work Experience, Occupation, and Earnings: 1984*, Current Population Reports, P-70, No. 10 (Census Bureau, 1987), Table 11.

19. Isaac Shapiro, *No Escape: The Minimum Wage and Poverty* (Center on Budget and Policy Priorities, 1987), p. 19.

20. American Bar Association, "The 'Black Box' of Home Care Quality," Report to the House Select Committee on Aging (August 1986), p. 29.

21. U.S. Senate Committee on Aging, "Home Care at the Crossroads," Special Committee on Aging (April 1988), p. 20; and Foundation for Hospice and Homecare, "Basic Home Care Statistics: The Industry 1988," (1988), p. 6.

22. *Ibid* , "Home Care at the Crossroads."

23. Valeria Watkins and Will Kirby, "Health Care Facilities Participating in Medicare and Medicaid Programs, 1987," *Health Care Financing Review* 9 (Winter 1987), p. 101; figures for 1979, 1980 and 1987 from HCFA, Office of Research, Demonstrations and Statistics.

24. HCFA data cited in: National Task Force on Gerontology and Geriatric Care Education in Allied Health, "An Aging Society: Implications for Health Care Needs," *Journal of Allied Health* 16 (November 1987), p. 317; and Foundation for Hospice and Homecare, "Basic Home Care Statistics: The Industry 1988," (1988), p. 8.

25. Foundation for Hospice and Home Care, "Basic Home Care Statistics: The Industry 1988," (1988), p. 20. Recent issues of the association's monthly journal (*Caring*, April and May 1988) devoted to paraprofessional home health workers do not estimate the number of home health aides nationwide.

26. Presentation of Elizabeth Gordon, Kimberly Quality Care, at the HHS National Conference on Home Care Quality: Issues and Accountability (June 1, 1988).

27. Testimony of Hadley Hall, "Black Box of Home Care Quality," Hearing before the House Select Committee on Aging (July 29, 1986), p. 67.

28. National Center for Health Statistics, G. Gloria Kapantais, "Decennial Census Data for Selected Health Occupations, United States, 1980," *Vital and Health Statistics* Series 14, No. 31, December 1985, pp. 3 and 13.

29. Bureau of Labor Statistics, *Projections 2000,* Bulletin 2302 (Department of Labor, March 1988), p. 51.

30. Bruce Lambert, "Home Care Aides Reach Contract with Raise of 42% Over 3 Years," New York Times (April 1, 1988), p. B-2; *We Who Care: The Story of Los Angeles County's Homecare Workers* (Homecare Workers Union, SEIU Local 434, January 1988), p. 1.

31. Penny Feldman and Alice Sapienza, "Comparison of Questionaire Results Across Sites: Homemaker/Home Health Aide Survey," Unpublished Report (Harvard University School of Public Health, January 1987), pp. 2-3.

32. Rebecca Donovan, "The Health and Social Needs of Home Care Workers: Preliminary Report," in *Plight of the Home Care Worker: Report of the Manhattan Borough President's Hearing on April 29, 1987* (January 1988), pp. 97-113; and Tarki Lombardi, "Recruitment, Training and Retention of Home Care Workers: A Serious Problem," Health Bulletin #88, New York State Senate Health Committee, Task Force Progress Report, December 1, 1987), pp. 2-5.

33. See note 31.

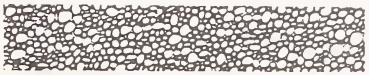
34. See note 30, *We Who Care*, pp. 18 and 20.

35. *Homemaker-Home Health Aide Services*, Administration on Aging Occasional Papers in Gerontology, No. 2 (Department of Health, Education, and Welfare, 1977), p. 15.

36. Rick Surpin, "Improved Working Conditions Lead to Improved Quality," *Caring* 7 (May 1988), p. 28. NAHC is not alone in covering only executives in its compensation surveys. The Foundation of the American College of Health Care Administrators recently published an in-depth study examining only nursing home administrators (*Professional Nursing Home Compensation Study*, 1988).

37. See note 1, Institute of Medicine, p. 11 and p. 90.

38. "Home Health Aide Services for Medicare Patients," Office of the Inspector General (Dept. of Health and Human Services, April 1987), pp. 15-16; and note 29, Lombardi, pp. 2 and 5.



39. See note 20, American Bar Association, pp. 57 and 59.

40. See note 16, Burger, p. 14 and Appendix; and Karen Erdman and Sidney M. Wolfe, M.D., *Poor Health Care for Poor Americans: A Ranking of State Medicaid Programs* (Public Citizen Health Research Group, 1987), p. 81.

41. Gail Wagnild, "A Descriptive Study of Nurse's Aide Turnover in Long-Term Care Facilities," *Journal of Long-Term Care Administration* 16 (Spring 1988), pp. 21-22.

42. See Constance Thomas, "States Respond to Critical Shortage of Nurses," *State Health Notes* No. 82 (Intergovernmental Health Policy Project, George Washington University, May 1988), pp. 1-3.

43. Bureau of Labor Statistics, *National Industry-Occupational Matrix, 1986-20* p. 524; and *Projections 2000*, BLS Bulletin 2302 (March 1988), p. 51.

44. *Ibid., Projections*, p. 56-57.

45. "Nursing Home Nurse Shortages," fact sheet (American Health Care Association, 1988); and interview with Pat Jones, National Association for Home Care, May 1988.

46. Statements of Reps. Panetta and Rostenkowski, *Congressional Record* 134, No. 83 (June 8, 1988), H 4033-4044.

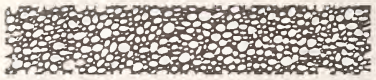
47. Task Force, "Problems on the Supply Side: The Homemaker Shortage in Massachusetts," March 1987. See also note 33, p. 29.

48. Anne Hegland, "Creative Incentives Reduce Turnover, Aid Recruitment," *Today's Nursing Home* 9 (May 1988), pp. 1, 22-25.

49. "Adopt Wage Pass-Through for Minimum Wage Increase," fact sheet, (American Health Care Association, May 1988).

50. Van Ellet, "Providers Find Nursing Pools Formidable Competitors," *Provider* (April 1988), 43-44; and "Regulate Nurse Pools to Ensure Quality, Control Costs," fact sheet (American Health Care Association, May 1988).

51. Andrea Sankar, Robert Newcomer and Juanita Wood, "Prospective Payment: Systemic Effects on the Provision of Community Care for the Elderly," *Home Health Care Services Quarterly* 7 (Summer 1986), p. 105.



52. "The Attempted Dismantling of the Medicare Home Health Benefit: A Report of the Congress," (National Association for Home Care, July 21, 1986), pp. 64-65; Sheila Leader, *Home Health Benefits Under Medicare* (American Association of Retired Persons, September 1986), pp. 13-17; "Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs," General Accounting Office (December 1986), pp. 56-57. Two other studies document that home health patients and nursing homes residents are more disabled and require more care in the post-PPS period: interview with Dr. Carol Estes, UCSF Aging Health Policy Center, March 1988; and Peter Shaughnessy, Andrew Kramer, and Mary Pettigrew, "Findings on Case Mix and Quality of Care in Nursing Homes and Home Health Agencies," (Univ. of Colorado, Health Sciences Center, July 1987).

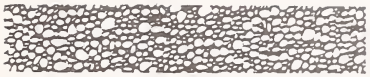
53. Martha Mohler, "Improved Nurse Staffing: A Priority for the Safety and Quality of Care in U.S. Nursing Homes," Report of a Study Done for the U.S. Senate Special Committee on Aging, October 1987, p. 6 and Exhibit D.

54. See: *Secretary's Commission on Nursing, Interim Report* (Department of Health and Human Services, July 1988), pp. I 6-10, and IV 12.

55. The changes were made in the Catastrophic Health Insurance measure, PL 100-360, signed into law July, 1988.

56. Sallie Tisdale, "Harvest Moon: Portrait of a Nursing Home," excerpted in *American Journal of Nursing* (March 1988), p. 299.

57. See: Ruth Needleman and Anne Nelson, "Policy Implications: The Worth of Women's Work," and Timothy Diamond, "Social Policy and Everyday Life in Nursing Homes: A Critical Ethnography," in *The Worth of Women's Work* (State University of New York Press, 1988). Chai Feldblum includes a feminist analysis of the caregiver role, but limits the discussion to unpaid caregivers in "Home Health Care for the Elderly: Programs, Problems, and Potentials," *Harvard Journal on Legislation* 22 (Winter 1985), pp. 246-254.



Appendix

Chronic Care Worker Bill of Rights

As a person providing daily personal care to chronically ill and disabled individuals in their homes or in a nursing home, I have the right to:

(1) a fair hourly wage that allows me and my family to live with dignity; overtime pay; shift differentials for night/weekend/holiday/24-hour care; in addition, as a home care worker, a differential for care of more than one person in the same household and for complex cases; paid travel between clients during the day; and a guaranteed number of hours of work each week;

(2) the kinds of benefits most workers take for granted: rest break, lunch break, sick leave, paid vacations and holidays (pro-rated for part-timers); comprehensive health insurance (with family coverage as an option) and a retirement plan/pension;

(3) be free of pressure to work double shifts, around the clock, and more than 40 hours per week if I am unable or unwilling to do so;

(4) adequate staffing, equipment, supplies, and time needed to meet my responsibilities to the persons I care for;

(5) appropriate paid training that meets federal and state requirements and prepares me to do my job (including information about the needs of special groups, such as persons who are dying, persons with Alzheimer's disease, AIDS, or mental health problems, and—especially as a home care worker—a full orientation to new clients);

(6) in-service training and continuing education courses to increase my skills; opportunities to climb a career ladder (for example, paid release time and allowances for educational expenses);

(7) adequate on-the-job supervision that helps me identify any weaknesses and recognizes my strengths as a chronic care worker; two-way communication with my supervisor and the agency/insitution for which I work;

(8) information about my responsibilities, role and tasks—which the agency makes clear to me, the persons I care for, and their families;

(9) forms of support that give me the opportunity to meet with other workers to talk over common problems and how to deal with them; and

(10) be counted as a valued member of the nursing home or home care team (for example, to be included in staff meetings and patient care conferences, to be issued a name tag and uniforms).

Chronic Care Workers: A Call to Action

Chronic care workers and their advocates pledge their commitment and urge others to support the following actions:

- Advocate passage of federal legislation increasing the minimum wage, requiring employers to provide basic health coverage to all workers and pro-rata benefits to part-time workers.
- Develop public education campaigns designed to:
  —find out what the general public knows about chronic care workers (using, for example, a national poll or focus groups) and what they consider a reasonable wage they would expect to pay if they needed help
  —increase awareness of chronic care workers' wages, benefits and working conditions (perhaps through public service announcements—"Let's take care of caregivers").
- Advocate a long-term care policy that is universally available to all Americans and addresses the working conditions of chronic care workers.
- Monitor the implementation of federal nursing home reform legislation and advocate nursing aides' concerns.
- Develop and advocate a research agenda, including such topics as:
  —data collection on the home health industry, especially non-certified groups
  —pay equity studies of health care service workers
  —demographic research on chronic care workers
  —studies of the health and disability of workers
  —special needs of immigrant women who are chronic care workers.

- Advocate that detailed information on nursing aides be included in the 1990 National Nursing Home Survey; that the Public Health Service's Bureau of Nursing include nursing and home health aides within its range of concerns.
- Develop model state legislation and regulatory actions that address the wages, benefits, and working conditions of chronic care workers who are paid with state funds; develop model state bills aimed at licensing and regulating all home health agencies.
- Undertake special education and advocacy efforts targeting key groups:
  —aging advocates, who are natural allies in the quest to improve quality of care by improving wages, benefits and training
  —women's organizations, who are concerned about caregiving, pay equity and women in service industry jobs
  —unions, civil rights, church and other groups that work for social justice and are concerned about worker exploitation and the status of minorities.
- Develop a model program for organizing and coalition building at the local level, that would bring together workers, aging and women's group advocates, and others concerned about long-term care and chronic care workers.
- Explore areas of mutual concern between chronic care workers and provider groups (particularly non-profit agencies and institutions), developing shared actions around such issues as federal cost-containment efforts.

The author thanks many of the persons whose work is cited here who, along with other individuals, shared information and ideas. Special thanks to William Wilkinson, on AFSCME Research staff, for bibliographic searches and other reference help, and to Carol Regan, AFSCME public policy staff.

Mr. WAXMAN. Thank you for your testimony.
Mr. August.

STATEMENT OF JOHN AUGUST

Mr. AUGUST. I am John August, president of District 1199P, of the Service Employees International Union in Pennsylvania. I also serve the union's health care division board.

On behalf of our union's 933,000 members, I thank you, Mr. Chairman, for the opportunity to testify on the current legislative effort to improve the wages, benefits, and working lives of nursing home workers.

The majority of our nursing home members are the registered and licensed practical nurses and nurse aides who provide the bulk of direct patient care and who are among the most undervalued caregivers in the health care system.

Reform of the Medicaid reimbursement system is long overdue. As the largest purchaser of nursing home services, Medicaid policies directly affect compensation practices.

Unfortunately, Medicaid payments are inadequate to finance wages, staffing, and patient care. Moreover, aggressive Federal cost containment policies and shrinking State budgets are prompting States to cut Medicaid outlays. In response, nursing homeowners squeeze labor costs which are 80 percent of operating expenses.

Workers bear the brunt of Medicaid cutbacks. Women and men who work in nursing homes are among the worst paid in the economy. The average wage of nursing home worker employed year round is below the Federal poverty level for a family of four. Nurse aides are even worse off. They often start at the minimum wage.

We believe in the union that engaging in collective bargaining is our most important work. But we are here to say that collective bargaining is not going to fix this.

Our members would rather serve than strike. But I want to tell you that in the last 6 months, we have negotiated 21 contracts in nursing homes in Pennsylvania. Every one went down to the wire; every one.

Nursing home workers typically lack even basic benefits such as health insurance and pension plans. Many can't afford the employers' health plan because of high monthly payments for family coverage and heavy upfront deductibles.

Even though nursing home wages have not kept pace with inflation, spending for nursing home care has risen at two to three times the general rate of inflation. Of the billions of dollars pouring into the nursing home industry each year, little flows to improvements in wages and benefits. Nursing home pay lags far behind the hospital sector.

Wide gaps exist for every profession. In Pittsburgh, Congressman Walgren, a typical hospital nurse aide will make $8 an hour, but a nursing home nurses' aide will make between $4 and $5.

An LPN employed by a hospital can expect to earn 20 to 30 percent more than one employed by a nursing home. Hospital aides earn 60 percent more than their nursing home counterparts.

Defunding of Medicaid at the Federal and State levels has created a labor market crisis. The RN vacancy rate of registered

nurses is double the rate reported by acute care hospitals. We think the shortage of nurses in nursing homes may be more critical than for hospitals. Vacancy rates for LPN's and nurse aides are excessive.

With staff shortages come astronomical turnover rates. In a year, the typical nursing home may see 50 to 100 percent turnover among nurses and 100 to 200 percent turnover among nurse aides.

We also want to point out that in a 1990 study by the Bureau of Labor Statistics on occupational injury, it was determined that nursing home workers are injured twice as much as hospital workers. There is also a direct correlation between the high turnover and high incidents of injury in that report. Nursing homes, unless they are able to compete in the broader health care labor market, will continue to lose experienced staff.

SEIU believes security and parity with hospital workers would go a long way towards relieving the labor crisis. One example is in Connecticut, where reimbursement policy is provided for increased wages and where some nursing home workers make $9 or $10 an hour. Connecticut's turnover rate is among the lowest in the country. At the other extreme, Texas, where the average wage is well under $4 an hour, annual turnover rates exceed 250 percent. Connecticut is the exception to the rule.

Congress has taken a number of significant steps to improve conditions in the nursing home industry. The OBRA 1987 nursing home training standards were an important first step towards improving the quality of health care.

H.R. 1649 takes the second step to address the issue of fair wages and benefits. It will provide the missing link between training and higher, improved wages. SEIU applauds H.R. 1649's requirement for federally mandated minimum nursing home wage and benefit standards.

But we believe the bill's approach to enforcement and accountability must be strengthened. Our attempts to provide high quality care may be doomed until we address the key issue of staffing.

I wish to thank you for this opportunity to testify. I am happy to answer any questions you may have.

[The prepared statement of Mr. August follows:]

PREPARED STATEMENT OF JOHN AUGUST, PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION

I am John August, President, of District 1199P of the Service Employees International Union in Pennsylvania. I also serve on the union's Health Care Division Board.

On behalf of our union's 933,000 members, I thank you, Mr. Chairman, for the opportunity to testify on the current legislative effort to improve the wages, benefits, and working lives of nursing home workers.

The Service Employees International Union is the largest health care union in the United States, representing nearly 400,000 health care workers, including 74,000 registered and licensed practical nurses and nearly 100,000 nursing home workers.

The majority of our nursing home members are the registered and licensed practical nurses and nurse aides who provide the bulk of direct patient care and who are among the most undervalued care givers in the health care system.

As the single largest purchaser of nursing home services, Medicaid payment policies clearly influence nursing home operators decisions on the number and type of staff, on the wage and benefit levels paid to staff, as well as on the amount and quality of food, supplies, equipment, and other resources to be purchased. Half of

the industry's revenues, paying for part or all of the care of about two-thirds of nursing home residents, comes from Medicaid.

Although Medicaid payments are the major support of the industry, often rates are far below those necessary to finance adequate wages, staffing, and patient care. Moreover, aggressive federal cost containment policies and worsening fiscal situations in the states are prompting states to cut their expenditures for Medicaid. In response, nursing home owners tighten the squeeze on their operating expenses—80 percent of which are labor costs.

As a result, nursing home workers are bearing the brunt of Medicaid restrictions.

Wages: The women and men who work in nursing homes are among the worst paid in the economy. The average wage in the nursing home industry of a worker employed year-round is $11,263, which is below the federal poverty level for a family of four. Nurse aides, who comprise 42 percent of all nursing home workers, are even worse off. Nationally, a nurse aide in a nursing home averages $5.07 per hour. An aide's starting salary is often the minimum wage.

Recent trends have not shown any improvements in these wage levels. In fact, nursing home workers' standard of living actually declined between 1978 and 1988, as wage increases failed to keep pace with inflation. The average hourly wage in the nursing home industry, after adjusting for inflation, decreased from $3.57 in 1978 to $3.49 in 1988. Consequently, nursing home workers are able to buy less with their meager earnings than they could a decade ago.

Although nursing home wages have not kept pace with inflation, expenditures for nursing home care have risen at two to three times the rate of general inflation. In 1977, personal health care expenditures for nursing home care totaled $13.0 billion, or $57 per capita. By 1987, this amount had jumped to $40.6 billion, or $161 per capita.

Aging demographics, the success of Medicare's program to contain hospital costs by discharging sick hospital patients to nursing homes, the early 1980s flurry of leveraged buyouts, and high medical inflation are largely responsible for tripling U.S. expenditures on nursing home care during this time period. Of the billions of dollars pouring into the nursing home industry each year, little flows to healthcare workers' wage improvements.

Benefits: In addition to earning poor wages, nursing home workers typically lack even basic benefits, such as health insurance and pension plans. The 1985 Bureau of Labor Statistics survey of nursing homes revealed that just 34 percent of nonprofessional nursing home workers had employer-paid hospitalization. Furthermore, only 20 percent had employer-paid pension plans.

Moreover, these figures overstate the actual extent of health care coverage in the industry. Our local unions are frequently able to negotiate some health benefits for nursing home workers, but the benefits are skimpy and the coverage often unaffordable. From its 1987 survey of access to health care among low-wage workers, SEIU found that 77 percent of nursing homes offered health coverage to their workers, but only 51 percent of these workers were insured—many through their spouse's plan. Many workers can't afford the employer's health plan because of high monthly payments for family coverage, heavy upfront deductibles, and poor benefits.

The experience of the nurse aides we represent at a private nursing home in Washington state provides a telling example. Although the employer offers health insurance to the regular, fulltime workers, few are able to accept the coverage. The employer only contributes a fraction of the cost towards single coverage and no payment towards dependent coverage. After a three month waiting period—during which time the worker has no benefits—the employer contributes just 30 percent towards the total cost for single coverage. The employer contribution then rises to 50 percent of single coverage after three years of service.

For workers in need of dependent coverage, the employer contribution towards the total family premium is negligible. The total premium for a family plan was $206.50 in 1989, but the employer contribution amounted to just $20.18. Consequently, the nursing home workers were responsible for paying the remaining $186.32 of the monthly premium. These exorbitant premium payments, coupled with a $300 annual deductible, render the plan unaffordable for the nurse aides who have a starting salary of $5.15 per hour. The premium payment alone consumes about one-quarter of their before tax income.

The low wages and poor benefits earned by nursing home workers are not typical of their counterparts in other healthcare industries. There is a wide gap between the wages of hospital and nursing home workers in every profession. According to the 1988 National Nursing survey, for example, fulltime general duty RNs working in hospitals earn an average of $27,196 per year while those employed in nursing

homes have an annual salary of just $22,381. Despite having comparable education and skills, RNs earn 22 percent more simply by working in a hospital.

The same type of wage gap between hospital and nursing home workers exists for LPNs and nurse aides as well. An LPN employed by a hospital can expect to earn 20 to 30 percent more than an LPN working in a nursing home. Among nurse aides the gap is even more dramatic. Nurse aides can earn up to 60 percent higher wages by working in a hospital than by working in a nursing home. And the gap has only continued to widen during the 1980s.

As a result of the Reagan-era cutbacks in social spending, Medicaid dollars account for a shrinking share of total nursing home expenditures. In 1977, 47.3 percent of nursing home funds came from Medicaid. By 1987, the Medicaid share had dropped to 43.9 percent. Private funding sources have had to pick up the slack. The percent distribution of private funds for nursing home care rose from 44.8 to 50.9 during this time period. This decline in Medicaid funding has had a direct impact on suppressing the wages of nursing home workers.

Not only are wages low, benefits almost nonexistent, living standards declining, and the wage gap between hospital and nursing home workers getting wider, we are now seeing signs that the system is further unraveling.

An extreme example can be seen in Michigan, where cost cutting actually resulted in average wages decreasing in key bench mark jobs in the nursing home industry. For instance, nominal average nurse aide wages decreased from $4.34 an hour in 1987 to $4.29 in 1989. As a result, real income declined sharply during this two-year period. Between 1987 and 1989, the cost of living rose 9.9 percent, translating into an 11 percent loss in purchasing power.

Labor shortages in many parts of the county combined with tight Medicaid reimbursement have created major staff retention and recruitment problems for many nursing home employers.

The vacancy rate of registered nurses stands at 19 percent in nursing homes, nearly double the rate reported by acute care hospitals. We also expect that licensed practical nurse vacancy rates in nursing homes are nearly as large as those of RNs—as in the case in acute care.

Our union is keenly aware of the nursing shortage, its root causes, the adverse effect it has on nurses, and the toll it is taking on the quality of care in all settings. It is our experience that the shortage of nurses in nursing homes may be a more critical problem than the nurse shortage in hospitals. Nursing home care is extremely sensitive to the lack of registered and licensed nurses. Since nurses supervise, direct and train a team of aides who deliver much of the direct patient care, if the nurse is absent it has a greater impact than in the hospital setting.

Although, we do not have precise vacancy figures for nurse aides, in a 1987–88 survey conducted by the nursing home industry, over half of all nursing home administrators reported moderate to severe shortages of nurse aides. Vacancy rates for nurse aides in some states run as high as 25 percent.

Shortages of nursing home staff are exacerbated by chronically high turnover rates. Illustrating the industry's inability to retain an experienced work force, a typical nursing home may experience 50 to 100 percent annual turnover among nurses, and 100 to 200 percent annual turnover among its nurse aides.

This work force turnover is costly as nursing homes continually recruit, orient, and train new, inexperienced personnel. Studies estimate replacement costs at roughly three times the average monthly salary or about $2,500 for an average aide in 1989. Lets look at what this can mean for a state. The state of California expects to train 20,000 new nurse aides this year. The cost of replacing these aides could run as high as 50 million dollars.

Reduced turnover rates are generally associated with improved care for nursing home residents. High turnover reduces staff morale, prevents the development of close, caring relationships, and decreases the continuity of resident care.

Most observers, including the National Commission on Nursing, agree that inadequate pay and benefits are the primary obstacles to staff retention. Nursing homes, unless they are able to compete in the broader health care labor market, will continue to be their experienced staff. We see the vast majority of aides, dietary, and housekeeping workers leave their jobs in nursing homes to take other unskilled jobs in the service sector, many for pay increases as small as 15 to 25 cents per hour.

But we must not accept high turnover as inevitable or irreversible.

There are few places to look to get a sense of what would happen if nursing home wage rates were similar to hospital rates. However, one possible example is in Connecticut, where reimbursement policy has provided for increased wages, and where some nursing home workers make $9 or $10 an hour.

In contrast to other states, independent surveys of turnover rates show that Connecticut's turnover is among the lowest in the country. At the other extreme, Texas, where the average wage is well under $4.00 an hour, annual turnover rates exceed 250 percent.

Connecticut is the exception to the rule. If actions are not taken to reverse current national trends, depressed wages, unsatisfactory working conditions, chronic staff shortages, and high turnover will be long-term conditions in this industry in every state in the union.

The demographics show that these problems will get worse. The National Institute on Aging projects that there will be 2.3 million nursing home residents in the year 2000, up from 1.3 million in 1985. If we assume that the present ratios of residents to beds to staff remain constant, the demand for nursing assistants in nursing homes is likely to increase by 75 to 80 percent. If we assume some improvements in the staffing of nursing home care, demand for nursing assistants could grow to one million in 2000, nearly twice the number employed in nursing homes today.

Congress has taken a number of significant steps to improve conditions in the nursing home industry. OBRA 1987 implemented a number of the reforms recommended by the Institute of Medicine study. We see the OBRA nurse aide training standards as an important first step toward improving the quality of resident care and establishing a more highly skilled nursing home work force.

H.R. 1649 takes the second step—to address the issue of fair wages and benefits. As such, it will provide the missing link between training and higher improved wages that is needed to improve the quality of patient care. It will also bring immediate relief for the undervalued nursing home workforce.

By bringing nursing home worker wages and benefits to parity with the wages and benefits offered by other health care providers, House Bill 1649 would correct a fundamental labor market inequity.

We applaud H.R. 1649's requirement for federally mandated minimum nursing home wage and benefit standards. We are, however, concerned about the bill's approach to enforcement and accountability.

Accountability and Enforcement: To be effective, this bill must mandate the new minimum on the states and provide effective enforcement procedures to ensure compliance. Accountability and enforcement mechanisms should be simple, equitable, and as consistent as possible with existing regulatory schemes.

Effective enforcement of H.R. 1649 should be based on three components. First of all, it should be relatively easy to determine compliance. SEIU has extensive experience with "wage pass through" programs at the state level, and we found that it can be incredibly difficult to establish whether a provider has actually "passed through" to workers money provided by Medicaid.

H.R. 1649 takes a very simple and direct approach by establishing a minimum for nursing personnel in nursing homes. Once the minimum rate for a region is established, it should be a simple exercise to determine whether a minimum is being adhered to.

The second issue has to do with establishing a uniform method of determining the prevailing wage, and the selection of a credible and impartial agency to carry out this determination. Medicaid agencies as the payer in this situation don't qualify as impartial, nor would having different state agencies result in a uniform methodology.

The U.S. Department of Labor is the clear choice in this situation. DOL already performs prevailing wage determinations under both the Service Contract Act and the Davis-Bacon Act.

The legislative intent behind these existing,"prevailing wage" laws was to insure that the federal government—as the largest single contractor—did not depress community wage standards. And in fact, the bill employs a prevailing wage methodology similar to those applied by the DOL under these laws. Yet, Federal and state governments' influence on wage standards in the nursing home industry far exceed that of construction or services. Therefore, adjustments in the methodology are needed to achieve the intended effect of wage parity for the nursing home industry.

Finally, it must be decided who performs the enforcement and how. Here it makes sense to rely on the existing structure and authority of Medicaid. Compliance with this act should be a federal "requirement" of participation (formerly known as a "condition of participation"). HCFA would promulgate rules to add compliance with the provisions of this bill onto its survey methodology, and state survey and certification teams would determine whether individual providers were in compliance based on wage levels determined regularly by the Department of Labor. Noncompliance with this act would jeopardize a facility's certification in the Medic-

aid program, and it would be subject to the same range of sanctions as if, say, it was found not to have an RN on duty.

Now is the time to build the infrastructure for what we already know lies ahead in this industry. We cannot build this kind of capacity overnight. If we start now, it might not be too late.

H.R. 1649 takes the right approach in setting a minimum wage. This is easiest to enforce. The prevailing wage methodology needs to be adjusted and the levels should be set by the Department of Labor, the agency with the most experience and expertise in this area. Finally, compliance with this Act should be made a requirement of participation in the Medicaid program; compliance could easily be accomplished along with other survey and certification activity during annual inspections.

Minimum wages and benefits established under this bill will help ensure the capacity of the nursing home industry for today and the future and will complement existing federal, state, and industry efforts to attract and retain qualified and committed workers to care for the elderly.

But the Institute of Medicine agenda is unfinished. In addition to acknowledging the low wages and difficult working conditions of nursing home workers, the Institute of Medicine found nursing home staffing to be already dangerously below levels needed to provide even minimal patient care. They called on the industry to make raising staffing levels its top priority.

I want to tell you frankly that our attempts to provide high quality care may be doomed until we address the issue of staffing. We urge you to move forward with this key piece of the IOM agenda and establish federal minimum staffing standards.

I thank you for this opportunity to testify. I am happy to answer any questions you may have at this time.

Mr. WAXMAN. Thank you.

Mr. Kesterson.

STATEMENT OF DAVID KESTERSON

Mr. KESTERSON. Thank you, Mr. Chairman.

The purpose of H.R. 1649 is commendable, the need to provide for equitable compensation for all nursing personnel no matter which sector of the market they serve. This is a concern shared by many groups which represent nurses and nurse aides.

The National Federation of Licensed Practical Nurses supports such efforts. NFLPN is a professional association for licensed practical and licensed vocational nurses.

There are about 800,000 LPN's in the United States today. As many as 40 percent of these nurses are directly employed by institutions providing long-term health care. NFLPN believes the LPN and the LVN are essential nurses for today and for the future.

LPN's and LVN's carry a significant part of the nursing burden in the facilities we are concerned with. That in itself is both good and bad. On the one hand, LPN's are used effectively and to the fullest extent of their scope by many of these facilities. Nowhere else in the health care market are they used so well. Their employment in such a setting can result in real fulfillment and the finest sort of job satisfaction.

The missing ingredient is adequate compensation. LPN's are hands-on nurses. They are nurses who are trained to provide direct care to the patient. Many have chosen to stay at the particular facility they are in simply to maintain contact with patients. But in the face of lower wages, they burn out.

On the other hand, it is also in some of these facilities that LPN's and LVN's are pushed beyond their scope of practice, pushed into unsafe nursing sometimes by the type of care they must deliver and are forced to deliver. Perhaps more often, they are pushed by the number of patients they must care for.

NFLPN hopes the effect of a bill like H.R. 1649 would have two specific results.

One would be to attract more RN's and more LPN's to these facilities, thereby alleviating the problems associated with LPN's practicing outside the bounds of their scope of practice. That is a benefit to all concerned because it provides relief for the nurse and the sort of care that we are looking for our older population.

It would also help provide a proper mix of RN's and LPN's in areas where it is needed.

This is reasonable. It falls back to the nurse practice acts of the various States and comes into line with the entire philosophy of why we have RN's and LPN's in a supervisory relationship.

The second major effect, we would hope, would be to provide LPN's and other nursing personnel in the nursing facilities with just compensation. I stress that we should give the compensation to the nurses and not nurse aides.

At this point, speaking for LPN's and LVN's, we must be wary of what might happen to competent LPN'S serving in responsible roles where they are practicing within the scope of their license with the benefit of great experience.

LPN licensing has increased for 2 consecutive years. A large hospital corporation opened three accredited LPN education programs. Some of those LPN's who were unfairly removed will never fully recover the part of their career that has been lost.

Thus, when a bill such as H.R. 1649 moves us towards surface-based samples in order to properly evaluate wage and benefit differentials, it is of utmost importance that the sample be carefully planned to include and expect to find LPN's in important job functions in these nursing facilities and to work toward bringing their compensation in line with other nurses doing that work elsewhere, no matter what their license might be.

Living within the legal bounds of their licenses, we find LPN's and RN's often times can perform the same task. It is tempting to use licensing as a key to such a survey. That won't meet the need. I fear that would provide another way to keep LPN wages where they are now and result in another element to put into the RN need surveys. We have a problem with our national Government. As I ask you to consider this particular point that I have raised, I would tell you that unless you have in your congressional resources good information on what is happening to LPN's, you don't have it anywhere else.

This report to the President and to you is woefully deficient on what is happening with LPN's in this country.

I would commend you for the bill, Representative Walgren, but I would ask you to remember that we have nurses who are LPN's who need attention because they are giving a lot of it to the people we love.

[The prepared statement of Mr. Kesterson follows:]

PREPARED STATEMENT OF DAVID KESTERSON, EXECUTIVE DIRECTOR, NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.

The purpose of H.R. 1649 is laudable, in that it seeks to establish a means of raising the wages and benefits of nurses and nurses' aides employed by skilled nursing facilities and intermediate care facilities to parity with other nurses and nurses'

aides in the locality in which they work. The need to provide for equitable compensation for all nursing personnel, no matter which sector of the health care market they serve, is a concern shared by many groups which represent nurses and nurses' aides. The National Federation of Licensed Practical Nurses, Inc. strongly supports such efforts and is pleased to present this testimony with respect to the proposed legislation.

The National Federation of Licensed Practical Nurses, Inc. is the national professional association for licensed practical and licensed vocational nurses. There are about 800,000 LPNs in the United States today. As many as 40 percent of these nurses are directly employed by institutions providing long-term health care. NFLPN believes that the LPN and LVN are essential nurses for today and for the future.

Nursing personnel, as described in H.R. 1649, refers to the registered nurse [RN], the licensed practical or licensed vocational nurse [LP/VN] and nurses' aides. RNs and LP/VNs are licensed nurses, people who have satisfied specific courses of study and passed nationally administered examinations in order to be licensed by the state, territory or district in which they reside and/or work.

H.R. 1649 describes, in general terms, a process of conducting surveys by means of statistical sampling, thereby determining average rates of wages and benefits paid to nursing personnel. The use of statistical sampling always places great importance on defining the groups to be sampled and the attributes for which sample values are obtained. When a crucial element is eliminated from the definition or when a part of the total population is not sampled, the sample result can be unreliable. NFLPN is concerned that proper consideration be given to the benefits that are measured and the personnel categories that are used.

The measurement of benefits should be broad enough to include the types of benefits which may not have immediate financial impact, but which could have a considerable impact on a person's decision to accept one job opportunity over another. Examples include adult day care, child day care and flexible work scheduling. Benefits such as these can become key decision criteria even though one might not use these benefits until a later date, as in the instance of day care. There will be instances when such benefits could offset wages differences. Exploring and evaluating the impact of these benefits is valuable to all who have an interest in our national health care system.

Determining the classifications of nursing personnel for sampling is probably the most important element of the process set out in H.R. 1649. The easy way out would be to sample on the basis of license alone, RNs, LP/VNs and nurses' aides. Easy, yes, but surely disastrous. It would be wrong to include a nurse specialist with a graduate degree among staff nurses just as it would be wrong to include a charge nurse who is an LPN among staff nurses who are LPNs. The appropriate sample classifications must consider license, position, education and experience.

NFLPN is concerned that LPNs who play important and valuable roles in providing nursing services be so recognized and accordingly compensated. For several years, nurses have debated the appropriate linkage that should exist between education and licensing. The debate focuses on whether there should be a standardized degree requirement for licensing. For RNs, the available educational routes to licensing are at least three in number, the Associate Degree, a Diploma from a hospital-based School of Nursing or a Bachelor of Science degree from a college or University. The educational route for the LP/VN is generally a twelve month program, with North Dakota, which requires an Associate Degree, being the exception. The debate continues, a debate where there is generous evidence for any side one may choose.

Because the debate has focused on education, the value of experience has often been overlooked in staffing and compensation decisions, especially when LP/VNs are concerned. It is important to recognize, for purposes of sampling for compensation, that there are not a few LP/VNs who have proved their abilities to fulfill supervisory responsibilities while working within the scope of their license. The sample for any survey should include those people and others of a similar nature as a class.

It is essential that legislation which sets out to provide parity in compensation to nursing personnel completes its task, making certain that the increased compensation is, in fact, received by those who deserve it by virtue of their job classification and their existing rate of pay. To accomplish this will require a more detailed approach than has been initially presented in the bill.

RNs and LP/VNs, then, are the people to whom the word nurse applies. Although members of this Subcommittee are aware of this distinction, but our national government, both in its Legislative and Executive branches, often ignores the fact that

LP/VNs are recognized as nurses by the states which form the United States. The word "nurse" has been too often appropriated for RNs alone. Examples that spring to mind are the funds that Congress has set aside for nursing education, where not a penny has gone to practical nurse education and the current and past Commissions on the Nursing Shortage appointed by the Secretaries of Health and Human Services. The national government has neglected LP/VNs.

Clear evidence of this neglect appears in the Seventh Report to the President and Congress on the Status of Health Personnel in the United States prepared by the U.S. Department of Health & Human Services. In Chapter VIII, Nursing, the fourth paragraph reads as follows: "Latest comprehensive data available for licensed practical/vocational nurses is from the 1983 National Sample Survey of Licensed Practical/Vocational Nurses (Jones, 1986). Significant changes have occurred in staffing configurations for the delivery of care as well as modes of delivery that have materially affected the use of licensed practical/vocational nurses. These changes could have seriously affected the overall supply and availability of these nurses. Lack of current, complete data precludes development of current and future estimates of the supply and distribution of and requirements for licensed practical/vocational nurses."

While virtually avoiding any mention of LP/VNs in the remainder of the chapter on Nursing, the chapter does not recommend obtaining new LP/VN data. The report has one paragraph on Practical Nurse education programs and presents a projection for LP/VN requirements for 2000, showing a projected requirement for LPNs which is less than the total of LP/VNs who will be licensed, at present rates, during this decade of the nineties. It is ridiculous for a report from our national government to give more space to foreign nurses than to our own citizens who are LP/VNs.

LPNs and LVNs serve well in the nursing facilities with which H.R. 1649 is concerned. They are a valuable asset to the nation. They are, insofar as the attention and care received from their national government, victims of what appears to be "benign neglect."

It is the hope of NFLPN that these words will help the Subcommittee in its deliberations on H.R. 1649, and that the members of the Subcommittee will be more informed of the significant role of LPNs and LVNs in providing nursing care to our citizens.

Mr. WAXMAN. Thank you very much.

I want to ask each member of the panel to respond to this question.

In her written statement on behalf of the State Medicaid Directors, Ms. Fuller argues against the Walgren proposal on the ground that wages and benefits are not the major cause of shortages and turnover. In her view, "nursing personnel turnover is due to a variety of dissatisfactions, many of which are more causal than wages and benefits." She cites the high degree of burnout in geriatric medicine, the routine nature of the work, the highly institutional setting and rigid paperwork requirements resulting from Federal regulations.

I would like to know your reactions to that.

Mr. Kesterson.

Mr. KESTERSON. I possibly spoke to part of that in my testimony.

Our nurses are there in nursing homes in many cases because they like the contact with the patient. As an editor of our quarterly magazine, I am continually being bombarded by manuscripts that speak of the joys of working in those facilities.

We recently published one piece in the magazine that specifically spoke of the pressure of being able to allow a person who was elderly to die the way they wanted to in a dignified—not pleasant—but a dignified manner in accordance with their wishes.

Our people don't burn out if they choose nursing homes because of the work there, for the most part. They burn out because they can't reconcile what they get paid with what they do.

Mr. WAXMAN. Mr. August.

Mr. AUGUST. Yes, a couple of thoughts. One is that in having a lot of contact with nursing home workers as I do, I can tell you that in most communities in Pennsylvania, an entry level job in a nursing home is comparable in pay to work in other service jobs, including the fast food industry, hotel restaurants, and so on.

I can tell you that in this revolving door of turn over, what is said on the way out, is that this work is too demanding. Workers say "I am going to do something else if I can't get paid the same or more."

Mr. WAXMAN. You disagree with her statement?

Mr. AUGUST. Absolutely. I think it is incorrect.

Mr. WAXMAN. Ms. Sackman.

Ms. SACKMAN. Mr. Waxman, I think if you look at the studies done—we are currently finishing one in California; the final report will be coming out next week—there is no question that wages are very much a prime reason for people not coming into the profession.

Around that wage question is—I think Ms. Scuffle addressed the wage compression issue—we may have the entry level wages for registered nurses up a little bit, but it caps out in 4 years.

When you get to nursing homes talking about registered nurses and licensed vocational nurses, the difference in pay at the entry level is abhorrent. There is no profession at all.

I would also say, to some extent, the workload in the nursing home facilities has changed. This is particularly true in the last 5 years because of the acuteness of the patients and because the patients are being moved out of the acute care hospitals into the nursing homes. Like a revolving door, they are coming back into the acute care hospitals because the staffing is not what it should be in the nursing homes. The patients are not getting care for their illness and end up being readmitted to the hospital.

Mr. WAXMAN. Ms. Scuffle.

Ms. SCUFFLE. I agree what has been said by previous members of the panel. Burnout does occur. The reason I see it occur is many times when you have one vacancy, you are asking the rest of your staff to pick up those hours to be there so you do have coverage.

As people continue to give of themselves, work longer hours, work more than they had intended and realize that the things at home are not being taken care of while they are continuing to work, they do tend to burnout. They want to be with the patients, they want to do what has to be done. They won't leave them.

On all levels, the RN, the LPN or the aide, are all giving of themselves emotionally as well as physically. That does create burnout. If the salaries were comparable to other areas of nursing, not only in the hospital but in other fields, too, then you would have people able to be recruited. That is what I see as the big part of the problem.

Another factor is that when you have a vacancy, it is very, very difficult to attract someone. You just can't get them in. As I mentioned in my previous statement, for the beginning salary—and I called around to many of the facilities to get some data so that I would be on top of what I am trying to talk about—at all levels, many of the nursing homes do pay a reasonable salary, but that is

it. They don't go too much higher. They may give them a dollar increase now and then. But the increases are not routine as they are in the hospital and as they are in many hospital-related facilities.

Mr. WAXMAN. Thank you very much.

Mr. Nielson.

Mr. NIELSON. Thank you, Mr. Chairman.

I think I can relate to Mr. Kesterson's remarks. The daughter I mentioned previously was an LPN first and then she worked in a nursing home.

She had an opportunity to go to work in the hospital for better wages, but she also had an opportunity to work on a program where she could get an RN. She facetiously called the RN the rich nurse and the LPN the low-paid nurse.

I am sure that is the jargon used in the industry. There is a differential which is artificial when they perform the same duties. I appreciate what you are saying there.

When I talk to Dr. Harrington, I wasn't implying there was not a need for RN's. There is a need for them at every level. There is a need to recognize all the personnel.

In my experience my mother was in a nursing home and died there at the age of 92 in 1984. Nurses who work in a nursery home are more attached to their patients. They are more kind and they are more personally involved than they could possibly be in a hospital setting.

I think they would work for lower wages because of the satisfaction they get from their work, but they can't work for too much lower wages. The differential is way too much. I certainly appreciate all four of you working to get those wages up.

I have some problems with the bill itself. I have some questions about what Ms. Burger said. If you got the wages up, that still would not solve the problem.

Would any of you like to comment on the proposition that wages are only one of the aspects, that there are four others that need to be addressed which may be equally as urgent as the wages.

Ms. Scuffle, I will start with you.

Ms. SCUFFLE. Thank you. I agree that there are other things that have to be tackled, but the dollar figure and the wages I see as a very primary point.

In addition to that, money that is needed to pay for continuing education within the facility so that the people who are giving the care are kept up to date. It has been mentioned by other people testifying here that the changes in the needs of the patient have been dramatic over the past few years, especially since DRG's went into effect in the hospitals. We are getting patients who have far greater nursing needs than they ever had before. We have staff who have been in the facility 10 or 11 years and they have to continually be brought up to date so the care they are giving is adequate to meet the patient needs.

Mr. NIELSON. If the wage rate differential were to be reduced so they were competitive to hospitals, would you still have a lot of problems?

If so, which ones?

Ms. SCUFFLE. I am sure we are not going to solve all the problems, but it will go a long way toward helping. I think once the income of the facility is a bit higher and they recognize that higher wages are needed, they are going to look at other ways in which to produce revenue rather than just keeping wages down.

Mr. NIELSON. Thank you.

Ms. Sackman.

Ms. SACKMAN. I would think it would go a long way, Mr. Nielson. I think that is particularly true in the situation where our acute care hospitals have skilled nursing care facilities attached to them. Many of our contracts cover those skilled nursing facilities where the nurses, LVN's and the trained aides or assistants or nursing aides—they may be called something different in the hospital industry—get paid exactly the same as those working in the acute care medical facility that is right next door.

The vacancy rates, the recruitment and retention rates are not any different in that second facility. In fact, they are a little better than they are in the acute medical care facility essentially because, I think, the stress level is a little different. It is a different type of care, although it has become more serious in the last couple of years and we have a higher acuteness of disability.

But, it is a more personal care. So I think you are going to find the overwork because there is so many vacancies. You are working double shifts, 7 days a week. If the wages are put up that is not happening, the stress levels that happen now aren't going to happen.

Mr. WAXMAN. Mr. August.

Mr. AUGUST. There are many, many impacts of the low wages. One I would like to address, which I think gets to the heart of many matters, is that there are direct correlations between increasing wages and decreasing turnover.

There are all kinds of studies that show that. High turnover in nursing homes is very bad for patient care. There is no continuity of care. Nursing homes are required to go out and hire temporary agencies who don't know the patients. On the other hand, there are clear studies in all areas that show that improving wages does, in fact, decrease turnover.

Mr. WAXMAN. Thank you, Mr. Nielson.

Mr. NIELSON. Could Mr. Kesterson answer the question also?

Mr. WAXMAN. Yes.

Mr. NIELSON. Thank you, Mr. Chairman.

Mr. KESTERSON. The increase in wages would surely help with the problems of burnout.

The other thing that is so important is the increase in staffing. If that increase in wages brings about an increase in staffing so that they have more nursing personnel for patients, then we don't have people left alone with nobody to meet their needs in the middle of the night.

Mr. NIELSON. Thank you.

Mr. WAXMAN. Mr. Walgren.

Mr. WALGREN. Thank you, Mr. Chairman.

I really find the testimony giving me a new perspective in terms of the attraction of people who work in these facilities.

We all know it is tough. Yet, from the outside I think it is hard for those of us that don't have direct contact with them to realize the rewards.

When Ms. Scuffle says that the retention rate in the sister facilities pays the same rate, retains nursing on a better level than does the hospital-based services, that is the most powerful statement of the role of wages in this area, it would seem to me. That gives, I think, us a very different perspective on the leverage we would hope to have on this problem.

It seems to me that without that, we can say my gosh, no one will ever stay. The truth is that there are kinds of rewards at these facilities, emotional and perhaps stress levels, that are very, that make them attractive facilities to work in. And when people are not working in them, obviously there must be something screaming to drive them out the door.

We know that that is wages because it sticks out like a sore thumb.

I guess that is by way of saying that this concept that there is real evidence that people are very willing to work in nursing homes if they are given the adequate pay. That is very important to our bill.

The other point that I take is really underscored with importance is the effect of turnover and its relationship to pay.

I want to ask Mr. August, the Connecticut example, you indicate that Connecticut has had some mechanism for addressing pay needs in their reimbursement system that other States haven't had. How do they do that?

Mr. AUGUST. It is done by taking a look at the industry and the need to raise wages. Then there are direct programs within the Medicaid system to make sure the wage is increased.

There are direct payments to the nursing homes with operators who do business in Connecticut and Pennsylvania. They would say, "we would love to be able to give you the higher wages in Pennsylvania, but in Connecticut we know we are going to get reimbursed for it."

It is tied directly to the need to raise wages and benefits in Connecticut.

Mr. WALGREN. Is that across the scale of employees in the nursing home? Is it just limited to certain personnel?

Mr. AUGUST. It is across the board.

Mr. WALGREN. It applied to licensed and nurse aides?

Mr. AUGUST. Ninety percent of the work is done by nurse aides. That is where most of the money would have gone.

Mr. WALGREN. You said that in every one of your negotiations in Pennsylvania, it went down to the wire literally, which is not the norm in organized labor negotiations, as you understand it, particularly in institutions where there is a real working bond between management and labor.

Often times those negotiations are understood from the start to be able to be resolved and resolved well in advance of the deadline. What is causing the nursing home industry this failure to agree?

Mr. AUGUST. Well, we have reached agreements in 20 of the 21 situations. We do have one strike going on.

The answer is, Congressman, that to adequately and honestly represent our members, we must at this point in history reflect their anger.

They are angry with the system very much. They are angry with the employer. They are angry when the employer comes to the bargaining table and says what they have been saying for years, "I would like to pay you more, but the system won't allow me to."

Then we go to the system at the State level. The State says, "Well, we are not sure; just not sure what to do."

The response from the workers is, "We can't live at poverty wages anymore." There is a high degree of anger.

Mr. WALGREN. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Bruce.

Mr. BRUCE. No questions.

Mr. WAXMAN. I want to thank the four of your for your testimony. It has been very helpful. We look forward to working with you on this legislation.

Our next panel represents the nursing home industry, the employers of the nurses and nurse aides who would be affected by H.R. 1649.

Dr. Paul Willging is the executive vice president of the American Health Care Association. And testifying on behalf of the American Association of Homes for the Aging is Mr. Michael Rodgers, senior vice president for Public Policy and Government Affairs.

We are pleased to have the two of you here. Your prepared statements will be in the record in full.

Please limit your oral remarks to no more than 5 minutes.

STATEMENTS OF PAUL WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION; AND MICHAEL F. RODGERS, SENIOR VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. WILLGING. Thank you.

I am Paul Willging, executive vice president of the American Health Care Association which through its 51 State affiliates represents the vast majority of nursing homes, 10,000 in total.

I wish to commend Congressman Walgren for having recognized and reflected in H.R. 1649 a very basic equation, namely, that to meet the promise, one has to also fulfill a very basic underlying premise. The premise of OBRA is not a well-crafted piece of legislation; it is not 15 or 20 additional regulations; it is not an additional enforcement system.

The promise was increased, improved, enhanced quality of care for the residents of America's nursing homes. Yet that promise was based on the premise of additional and better trained staff within American nursing homes. More RN's, more sophisticated RN's, better trained RN's, more LPN's, more sophisticated, better trained LPN's.

To meet that promise and premise, where do we stand today? Already in 1990, nursing homes suffer a vacancy rate twice that of any other part of the health care system. According to data published by the American Nurses Association, the vacancy rate in American nursing homes is approaching 18.9 percent.

On top of that existing vacancy rate comes OBRA as of October 1, 1990. To meet the basic minimum statutory requirements in terms of the staffing ratios enunciated in OBRA, we are talking about an additional 6,500 RN's and LPN's. Even that is not enough.

The staffing ratios indicated in OBRA are, in and of themselves, not necessarily sufficient given the higher acuteness levels in nursing home patients. If we were to take staffing levels, which is not unreasonable, there is no less than one primary caregiver for every eight patients during the day shift. No less than 1 primary caregiver for less than 10 patients on an evening shift. We are talking about yet an additional 3,000 primary health caregivers, aides and registered nurses.

As Congressman Bilirakis indicated in his remarks, when a nurse chooses or a nurses' aide chooses to enter that environment, the end result is to be penalized. The nursing personnel in American's nursing homes are paid on average across the country—varying obviously by region and type of personnel—36.4 percent less in annual wages than their counterparts in similar jobs in hospitals. Clearly this is a problem recognized for some number of years in this town.

Secretary Otis Bowen established a nursing commission. One of its primary recommendations was that parity and equity between the salaries paid nursing personnel in hospitals and the salaries paid nursing personnel in the nursing home industry must be established.

I think that is where we stand today. Are we as a country—is the Congress ready—to make that jump which will allow us to fulfill the promise of OBRA based on the premise of OBRA to provide the quality of care necessary for the residents of our nursing homes?

It will not be enough to craft a good piece of legislation, as indeed OBRA was. It will not be enough to craft regulations as at some point the Health Care Financing Administration may do. It will not be enough to, in effect, have a new enforcement system if the personnel are not there. If we in the industry cannot afford to hire those personnel, we will not see the kinds of quality promises fulfilled that were entailed in the OBRA legislation.

I very much support, as does the American Health Care Association, the legislation H.R. 1649 and commend this committee for having provided this critical public attention to the issues of high quality care in America's nursing homes.

Thank you very much.

[Testimony resumes on p. 143.]

[The prepared statement of Mr. Willging follows:]

STATEMENT OF AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman, members of the subcommittee, I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA). AHCA is the professional trade association which represents more than ten thousand individual nursing facilities through its fifty-one constituent state associations. I am pleased to appear today to offer our views on H.R. 1649, legislation that would permit nursing facilities participating in the Medicaid program to pay, on a phased-in basis, nursing personnel at a rate at least equal to the mean rate paid nursing personnel employed outside nursing facilities.

Before I begin my presentation, I would like to take this opportunity to commend the author of this proposal, Representative Doug Walgren (D-PA), for his leadership in focusing Congressional attention on this very important matter. Virtually all providers of Medicaid services share one common element, that is, their inability to economically compete for labor in a compressed market. As a rule, private payors, private insurance carriers, and federal health insurance extend higher levels of reimbursement for labor than do the several state Medicaid programs. The discretionary authority extended to the states under the laws of Title XIX of the Social Security Act which have led to the establishment of insufficient reimbursement allowances for labor have led to a crisis within the health care delivery system. That is, the inability of Medicaid providers to attract sufficient numbers of qualified nursing personnel,

both technical as well as professional, in a highly competitive market.

Congressman Walgren's legislation would alleviate the disparity between Medicaid and other providers by requiring states to make payments for the costs of nursing personnel in nursing facilities at a rate that is at least equal to the minimum rate of wages and benefits in a given locality. H.R. 1649 provides for a specific methodology within which mean salaries could be calculated, and establishes labor reimbursement criteria which could be used to evaluate the adequacy of any reimbursement proposal. The nursing home industry is extremely dependent upon labor to fulfill its mission. Without adequate reimbursements to cover the costs associated with this labor component, our industry will be unable to realize the challenge it currently faces, and more importantly, will find its ability to go beyond the nurse staffing minimums established by this Congress, virtually impossible to achieve.

Current Medicaid reimbursement principles are regulated by the Federal government in a rather basic fashion. The "cap" on Medicaid reimbursement rates is created by the establishment of an upper limit which, in the aggregate, may not exceed established Medicare reimbursement levels for similar services. The lower limit is set by the various states at a limit which is sufficient to cover the costs incurred by economically and efficiently operated facilities. Clearly, this standard has

failed. Salary data provide insight into the problem. AHCA data shows that nursing personnel employed in nursing homes earn an average of 26.7 percent less than their counterparts in hospitals. More specifically, RNs in nursing homes earn 85 percent of their hospital counterparts; LPNs earn 93.6 percent of their hospital counterparts; and nurse's aides working in nursing homes earn 68.2 percent of their hospital counterparts. While on the surface it would appear that nursing home based LPNs are close to their hospital counterparts, it should be noted that the employment rate of LPNs in hospitals is limited; for all intents and purposes, nursing homes set the market rate for LPNs. The problem associated with the lower limits is that during the past several years, Medicaid reimbursements have been set at levels far below the costs of providing services. For nursing homes, the increased number of elderly, the increased acuity level of residents, the expansion of Medicaid funded health care services, as well as pressure on state budgets have contributed to the establishment and perpetuation of inadequate reimbursements for nursing home services.

Compounding this problem is the current shortage of all categories of nursing personnel. Competition for registered nurses, as well as licensed vocational and practical nurses has exacerbated the problem by driving wages upward while Medicaid labor reimbursements have failed to keep pace. The net result these inadequate payments have placed nursing homes at a sever disadvantage in the competition for labor. Enactment of H.R.

1649 would address and resolve this problem by simply establishing a fair reimbursement system for nursing labor costs incurred by nursing facilities.

BACKGROUND

The Omnibus Budget Reconciliation Act of 1987 (P.L.100-203) contains several provisions aimed at increasing the quality of care as well as the quality of life of nursing home residents. AHCA supported the reforms embodied in OBRA '87 and is working with its constituent state associations as the October 1, 1990 implementation date draws near to assure that these reforms become a reality. A major component of the OBRA '87 provisions were increases in nursing personnel. Prior to OBRA '87, nurse staffing standards were established by the individual states, relying primarily upon the services of licensed nursing personnel and nurses aides to provide direct services to residents. In nursing homes, registered nurses served primarily in an administrative capacity, or as charge or staff nurses in skilled nursing facilities with higher than average acuity levels.

During the debate on the nursing home reform provisions of OBRA '87, Congressman Walgren proposed an amendment which would have required nursing facilities to provide the services of at least one registered nurse in each facility to be on duty 24 hours per day. This proposal transcended the nursing home reform bill's original staffing requirements. The Walgren amendment was

actively lobbied by representatives of organized nursing, but ultimately, in the full Energy and Commerce Committee markup, the Walgren amendment failed on a 20-20 tie vote. During the debate, it became clear that the members of the committee were genuinely interested in assuring that residents of nursing facilities have access to the services of registered nurses. Although the Walgren proposal was a laudable goal, the nursing home industry expressed concerns regarding the availability of nursing personnel to fulfill such an aspiration. The current nursing shortage was not yet apparent during the fall of 1987 when OBRA was debated. However, many labor analysts predicted what has now been realized to be possibly the most severe shortage of nursing as well as other health care personnel in recent history. This phenomenon has been compounded by the increased demand for nursing personnel within the hospital community which has resulted due to a multitude of factors, not the least of which is a rise in patient acuity. In recognition of this shortage, Congress included waiver provisions for nursing facilities which, after diligent and quantifiable efforts, are unable to recruit sufficient numbers of nursing personnel to fulfill the minimum requirements ultimately mandated by OBRA. Since passage of OBRA in December 1987, the nursing shortage has worsened. As the nursing home industry faces the implementation of the OBRA '87 staffing requirements this coming October 1st, many facilities,

both urban as well as rural, are anticipating the filing of waiver applications with their state governments. While the granting of a waiver for these staffing requirements will offer a short term resolution to this problem, they will not solve it.

Subsequent to the passage of P.L.100-203, representatives of AHCA met with Congressman Walgren to develop a solution to the nursing home nurse staffing shortage. The product of these meetings was H.R. 1649, legislation that focuses upon increasing nursing staff availability in nursing homes by offering wages for nursing personnel which are competitive with hospitals and other health care providers within a given locality. The premise of the legislation was made succinctly by Congressman Walgen in his introductory statement which, in part read: "It is well documented that major reason nursing homes cannot attract and retain nursing staff is low pay."

PROVISIONS OF H.R. 1649

H.R. 1649 would amend title XIX of the Social Security Act to permit nursing facilities participating in the Medicaid program to pay, on a phased-in basis, nursing personnel at a rate at least equal to the mean rate paid nursing personnel employed outside nursing facilities.

H.R. 1649 directs the individual states to make payment for nursing facility services, including the costs of wages and

benefits of the facility's nursing personnel (including nurses' aides) who provide or supervise direct care of residents at a rate that is at least equal to the minimum rate of wages and benefits established for nursing personnel in a locality in the State. The calculation of a mean rate of wages and benefits paid in each locality in the state to nursing personnel would be established by conducting a survey of a statistically representative sample of nursing personnel outside of nursing facilities. This data would in turn be submitted to the Secretary of Health and Human Services, and once approved, would establish the adjusted minimum wage rate for the various categories of nursing personnel working outside of nursing facilities. A similar computation would be made for nursing personnel working in nursing facilities to establish a baseline wage rate for those nurses and nursing personnel. The intent of the legislation is to bring nursing personnel at the nursing facility baseline rate up to the adjusted minimum wage rate for nursing personnel working outside of nursing facilities. This upward adjustment would be phased-in over a four year period in quarterly increments.

Safeguards from abuse are inherent in the proposal. Rather than set-aside a sum of money to be used for nursing wages, the established adjusted minimum wage rate in effect, becomes a minimum level which the states must reimburse facilities for their labor costs. In practice, little additional administrative burden is added to the reimbursement system. Any facility

attempting to abuse the system and recoup more than the actual expended wage funds would be subject to felony provisions currently in law. In addition, the legislation provides for the recovery by the State, from a nursing facility, such amounts that are paid to the facility for attaining the adjusted minimum rate for nursing costs, but are not expended by the facility. Conforming amendments for state plan amendments, where necessary, are also provided for in the proposal.

IMPACT OF THE NURSING SHORTAGE ON NURSING FACILITIES

Nursing homes provide continuous institutional care to their residents 24 hours per day. The level of these services varies from custodial nursing care to specialized nursing care for more seriously ill residents. Currently, the federal and state governments recognize two levels of nursing home care - skilled and intermediate. Skilled nursing facilities (SNFs) staffing requirements currently require that a RN serve as director of nursing on a full time basis, and provide continuous 24 hour coverage by a licensed nurse. Intermediate Care Facilities (ICFs) are not subject to federal staffing requirements. However, as of October 1, 1990, these staffing requirements will be dramatically affected with the implementation of the nursing home reform provisions of OBRA '87.

More than 70 percent of the costs associated with providing nursing facility services is attributable to labor costs. Of

this, the majority of costs are directly related to nursing services. Registered nurses, licensed practical and vocational nurses, and nurses aides provide direct patient care services to beneficiaries. It has been reported that more than 65 percent of all nursing facility personnel are nurse's aides, and that this group is responsible for providing more than 80 percent of all patient care services. However, as acuity levels of residents rises, the need for more licensed nursing personnel becomes apparent.

Unfortunately, the nation is currently in the midst of a nursing shortage that is impacting upon all segments of the provider community. The ability to recruit and retain adequate nursing personnel is becoming more and more difficult each day. This problem is not expected to abate anytime in the near future as evidenced by a decline in nursing school enrollments. Nursing facilities are particularly hard hit by the shortage with their inability to effectively compete with wages and benefits being offered by hospitals. In addition, the advent of health care reforms that were enacted by Congress in the early 1980s have created numerous job opportunities for professional nurses, further depleting the available supply for direct patient care services.

In December 1987, former Secretary of Health and Human Services, Otis Bowen, M.D., established the Secretary's Commission on Nursing to examine the causes of the nursing

shortage and to make recommendations on how both the public as well as the private sector could best address and resolve the problem. One of the Commission's first tasks was to identify where the shortage of nurses was most acute. Not surprisingly, they cited nursing homes as a segment of the health care delivery community suffering disproportionately from the shortage.

Once the Commission had completed its assessment of the shortage, it turned its attention to the development of specific solutions. Among its recommendations, the Commission cited two critical factors contributing to the shortage - nurse compensation and health care financing. In short, the Commission cited inadequate wages and severe wage compression over the span of an individual nurse's career to be a significant contributor to the ability to recruit students into the nursing profession. Secondly, they cited health care financing as being inadequate to recruit and retain sufficient nurse staffing. "The Commission recognizes that many employers of nurses, especially those in the nursing home and home health sectors, may not have sufficient financial resources to support the compensation enhancement advocated in the preceding recommendation" (i.e., compensation). The Commission specifically recommended that, "Congress should direct the creation of specific payment methodologies to assure equity between hospital nursing salaries for nurses working in nursing homes and home health agencies." H.R. 1649 mirrors this recommendation.

Compounding the problems associated with the nursing shortage in nursing homes is the image associated with these facilities. The patient population of nursing homes is, for the most part, comprised of elderly individuals with chronic illnesses. In addition, the perception of nursing homes having to deal with death and dying, as well as mental and physical deteriorations does not attract nurses who wish to work in a restorative environment such as a hospital. This image problem is compounded, and perceptually vindicated by the lower wages offered by nursing homes. Ironically, it is the nursing facility which has the potential to offer individual nurses the ability to practice their profession to the fullest extent and to provide restorative nursing care, yet has a more difficult time recruiting adequate staff to meet its needs.

Turnover, particularly among nurse's aides, is another problem compounding the shortage of nursing personnel in nursing homes. High turnover leads to staff shortages which consequently results in a lessening of patient care services. The National Center for Health Statistics (1979) nursing home survey identified that approximately 65 percent of all nursing home personnel are nurse's aides. Individual nursing facilities report turnover rates from 50 percent to 400 percent annually. Studies that have been conducted over the years have found wages and benefits to be a significant contributor to turnover rates. AHCA believes that not until these wages and benefits are raised

to competitive levels within a geographic region, will the nurse's aide population be stabilized.

The most recent study of nursing personnel shortages in nursing homes is reflected in a yet to be released survey conducted by the American Nurses' Association. Preliminary data from the 1989 survey found nursing shortages in 18.9 percent of nursing homes, 12.9 percent in home health agencies, and 10.5 percent in health maintenance organizations.

In sum, the capacity of nursing homes to provide quality care to residents is becoming increasingly jeopardized by the nursing shortage. The major contributing factor for this phenomenon can be directly linked to the individual nursing facility's inability to offer competitive wages and benefits to qualified applicants in a diminishing labor market.

INCREASES IN NURSE STAFFING REQUIREMENTS

With the passage of OBRA '87, several nurse staffing requirements will be imposed upon nursing facilities. It is also important to note that the distinction between SNFs and ICFs will be eliminated, and all such facilities will hence forth be deemed, "nursing facilities". Beginning on October 1, 1990, all Medicare certified facilities must provide 24 hour licensed nursing services sufficient to meet the needs of its residents. In addition, the services of a registered nurse must be available

8 hours per day, 7 days per week. Waivers for those RN services in excess of 40 hours per week are provided for in rural areas only, and are to be subjected to an annual review.

Medicaid staffing requirements mandated by OBRA '87 are similar in that they require 24 hour licensed nursing services and must also provide the services of a registered nurse for a least 8 consecutive hours a day, 7 days per week. Medicaid law will provide for waivers for licensed nursing services if the facility can demonstrate that it has been unable, despite diligent efforts, to recruit adequate nursing personnel. For the Medicaid program, the individual States have the authority to grant these waivers.

An April 1990 survey on nurse staffing needs in nursing homes conducted by the National Committee to Preserve Social Security and Medicare (NCPSSM) found that, "To meet the federal requirements effective October 1, 1990, thirty-four percent of the nursing homes need an additional 5,434 RNs and eight percent need an additional 1,103 LPNs." This anticipated demand for licensed nursing personnel, in conjunction with the high turnover rates associated with nurse' aides will make the administration of an individual facility's labor force, challenging to say the least. The NCPSSM study also compared current nurse's aide staffing ratios to a proposed nurse's aide standard developed by the American Nurses' Association which calls for a caregiver to patient ratio of 1:8 during the day shift, 1:10 evening, and 1:15

at night. When this standard was compared to current staffing patterns, it was concluded that 8,161 SNFs and 5,005 ICFs would require additional nurse's aides to meet this proposed standard.

In addition to the licensed nurse staffing requirements promulgated by OBRA '87, the law provides for required training of nurses' aides. As of October 1, 1990, all nurses aides must undergo a minimum of 75 hours of education and pass a state-approved competency evaluation program in order to become certified.

Clearly, the nursing-related requirements of this law represent a significant increase in responsibility of nursing facilities to recruit and retain qualified nursing personnel. The impact of the development of a new level of certified paraprofessional nursing personnel is still uncertain. It is obvious however that these new standards are being imposed at a time when the supply of qualified applicants is scarce, and that funding is, in our opinion, inadequate.

AHCA is firmly committed to enhancing the quality of patient care services. There is no argument that increased nurse staffing is the best way to immediately achieve a higher standard of care in nursing homes. Our concern is not with the policy proposal, but with the failure of both federal and state governments to adequately provide for the financial resources to achieve these worthwhile goals. Although waivers for these

staffing requirements have been included in law, we fear that an inordinate number of nursing facilities will be forced to seek such waivers in light of the current nursing shortage.

FUNDING RESOURCES FOR LONG TERM CARE

The patterns for financing nursing home care are significantly different from that of personal health care services. Private insurance and Medicare constitute almost half of all personal health care expenditures. However, these two payors account for less than 2 percent of nursing home care. Conversely, Medicaid pays for the nursing facility care services of 65 percent of all residents.

According to the Health Care Financing Administration (1986), national health care expenditures for nursing homes totaled $38.1 billion. Direct patient payments accounted for 50.9 percent, Medicaid for 41.5 percent, Medicare for 1.6 percent and other third parties for 6.0 percent. The fact that 65 percent of all nursing home residents are Medicaid beneficiaries while Medicaid funding is just more that 41 percent of revenues is a function of the inadequacy of Medicaid reimbursement rates. Interestingly, these figures demonstrate a shift in payment responsibility between private pay and Medicaid over time. In 1975, the Medicaid program(s) paid approximately 49 percent of all nursing home costs whereas in 1986, it financed just over 40 percent. Private payors, who in 1975 accounted for slightly more

than 40 percent of nursing home expenditures rose to more than 50 percent by 1986.

The AHCA has calculated the average daily cost of care in a nursing facility to be $55 per day, of which the proportion of wages and benefits to be just more than 72 percent. This figure dramatically demonstrates the labor intensive nature of nursing home care. Nursing staff alone account for 45 percent of these expenditures (wages and benefits). This data reinforces the significance of wages and benefits in nursing home staffing.

A fairly recent phenomenon impacting on the ability of nursing homes to secure adequate nurse staffing is the increased use of temporary nurse staffing agencies. The dynamics of the nursing labor market have fostered the development of temporary agencies that provide temporary staffing at prices generally above prevailing market prices for similar labor services. These agencies are often times attractive to potential recruits due to their ability to offer higher wages, better benefits, and importantly, more desirable schedules to their workforce.

Some states have attempted to thwart the use of these agencies by capping Medicaid limits on nursing salaries. The agencies argue that that is a restraint of free trade, the states contend that the agencies are profiteering at the expense of the Medicaid program. Aside from the merits of each argument, the issue demonstrates the critical nature of the nursing shortage.

CONCLUSIONS

Mr. Chairman, our testimony today does not attempt to offer solutions to, or resolve all of the issues associated with the insufficient numbers of nursing personnel available to work in the nursing home industry or elsewhere. What we have attempted to do however, is to identify those factors that contribute most heavily to the shortage of nursing personnel within our industry, and to offer our support for a proposed remedy.

As I have noted in my testimony several times, the failure of the Medicaid program to adequately fund nursing home services to achieve the levels of nurse staffing mandated by Congress has prohibited providers from achieving a level of care that goes beyond a minimum. Nursing homes have always failed in their competition with hospitals to secure adequate nursing personnel. Until nursing homes can offer the same level of wages and benefits that their counterparts in the acute care sector are able to afford, we have no reason to believe that things will change for the better.

OBRA '87 has presented our industry with a laudable goal of increasing our nurse staffing requirements dramatically. Although the staffing requirements are desirable, we are confounded as to how we will achieve these new goals while we are

hindered from achieving even minimum standards now in effect. There is no evidence that the current nursing shortage will wain anytime in the foreseeable future.

The only potential legislative solution to this problem that the AHCA is aware of is Congressman Walgren's bill, H.R. 1649. While we would welcome a resolution of all of the economic inequities in Medicaid reimbursement policies regarding nursing homes, a resolution of this matter with regards to nurse staffing would yield the greatest benefit in terms of quality care for residents. Thank you.

Mr. WAXMAN. Thank you.

I want to indicate we are being summoned to the House floor for a vote.

We are going to recess to respond to that vote and return as quickly as we can to hear your testimony and to go forward with the hearing.

[Brief recess.]

Mr. WALGREN [presiding]. Let me call us back to order.

The chairman will be returning immediately. We should start and return to Mr. Rodgers statement.

STATEMENT OF MICHAEL RODGERS

Mr. RODGERS. We appreciate the opportunity to testify this morning on behalf of the American Association of Homes for the Aging. I would like to commend Chairman Waxman for convening these hearings and also you, Mr. Walgren, for introducing legislation that we think takes an important first step to assuring quality.

The legislation before us today, H.R. 1649, recognizes two important factors. First is the importance of nursing personnel within nursing facilities. This committee is well aware that over half the employees within their facilities fall into this category. Second is that adequate financing needs to be provided to guarantee quality care.

In 1988, the Secretary's Commission on Nursing did an excellent job at documenting critical shortages of nursing personnel throughout the country, especially in rural areas. The report went on to talk about and document adequacy of compensation for all nursing personnel.

Clearly the problem is more acute in nursing facilities where registered nurses earn between 15, 25, or 35 percent less than their counterparts in hospitals. There is also quality disparity between licensed practical nurses and nurse aides.

I think that the subcommittee is well aware of the statistics and the reports that have been provided in relationship to problems with nursing personnel.

AAHA is especially concerned with the approaching date for new requirements for participation. Our concern is even exacerbated by the fact that, in spite of concerted efforts by the Congress to make sure HCFA and the States have been provided specific guidance in financing, very little has happened since the enactment of OBRA.

We would remind the committee AAHA supported the provisions of OBRA. Problems, we believe, however, are going to be expanded on October 1, 1990 when these additional staffing and training requirements go into place without adequate reimbursement at the present time.

We salute the provisions in H.R. 1649. It begins to recognize the importance of achieving wage parity for all nursing personnel. It is certainly an important first step in assuring quality. Additionally, the legislation, we believe will begin to create incentives for individuals to consider long-term nursing careers. It establishes a process to insure higher salary levels, gradually phased in as well as safeguards to insure the facilities use the increased reimbursement for nursing personnel.

We have, however, several concerns on how the legislation might be strengthened or further clarified. First of all, in committee markup or potential committee markup, we would hope the subcommittee would have additional specifications on methodologies for calculating mean nursing costs. We provided some examples in our testimony. Additionally, we think that the legislation needs to insure that States provide for adequate payment for these kinds of costs. The legislation might include, for instance, not only additional oversight on the part of the Health Care Financing Administration, but perhaps more oversight on the part of Congress in this regard.

We are going to see some wide disparities in costs right now. In Washington, for instance, the State has estimated the cost at 96 cents per day to implement OBRA. Our respective associations, however, come up with much different and much higher figures. California has indicated they are going to have a difficult time in paying for OBRA costs and there have been some reports they are not intending to pay for the increased costs associated with OBRA. Even in your home State, Mr. Walgren, the Federal courts have rejected the Medicaid plan as initiated by the State.

Second, we believe the legislation needs to insure continuous monitoring in nurses' wages and benefits. The legislation will correct problems currently but such assurances need to be provided for ongoing parity for nursing wages.

Third, we think Congress needs to consider Medicare payments under this legislation as well. We realize Medicare is not part of the jurisdiction of this committee, but certainly this committee has tremendous influence in the Congress. Perhaps you can convince the Ways and Means Committee of the importance of including nurse passthroughs as well.

Finally, we think the legislation needs to provide some provisions for career ladders for nursing personnel. The legislation establishes mean rates and we would like to see perhaps some additional incentives considered for those personnel who have worked in long-term care facilities for many years.

We look forward to working with the subcommittee and again extend our appreciation to you, Mr. Walgren, for your efforts in this regard.

[The prepared statement of Mr. Rodgers follows:]

PREPARED STATEMENT OF MICHAEL RODGERS, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman, Members of the Committee, I am Michael Rodgers, of the Ameri can Association of Homes for the Aging. We are a national nonprofit associatior representing over 3,500 nonprofit facilities providing health care, housing, continu ing care retirement programs, and community services to more than 500,000 olde individuals every day. Over seventy percent of AAHA homes are affiliated with reli gious organizations, while the remaining are sponsored by private foundations, fra ternal organizations, government agencies, unions and community groups. Witl strong community involvement and longstanding community ties, AAHA's member are committed to meeting the physical, social, emotional and spiritual needs of thei residents in a manner which enhances residents, sense of self-worth and dignity and allows them to function at their highest level of independence.

Mr. Chairman, we appreciate the opportunity to testify on behalf of our associa tion concerning the need for nursing personnel in our facilities to be compensated a rates comparable to hospitals and other similar employers.

The proposed legislation, H.R. 1649, is a response to the concerns of long-term care nursing facilities nationwide that, because of the severe shortage of nursing personnel at all levels, they will not be able to continue to assure quality care to their frail elderly and disabled residents. As critical as this problem is for hospitals and physicians, it is even more so for nursing facilities, most of which are unable to offer nursing personnel wages competitive to those offered by these other employers.

Concern about the shortage of registered nurses has been growing for several years, as nursing facilities reported increasing difficulties in filling vacancies. The Commission on Nursing of the Department of Health and Human Services, which reported in 1988, found a national average nursing vacancy rate of 11.3 percent in 1986. The rate for nursing facilities, however, was much higher—a startling 20 to 25 percent.

This shortage is likely to be exacerbated after October 1, 1990, when provisions of the Omnibus Budget Reconciliation Act of 1987 [OBRA] raise the staffing levels of intermediate care facilities by requiring licensed nursing personnel to be present in nursing facilities 24 hours a day, every day. OBRA also requires registered nurses on the day shift seven days a week. Nurse aides in nursing facilities are also required to meet minimum training and competency requirements which do not apply to other health care settings. AAHA supported these provisions of the law because we believe they will improve the quality of care in nursing facilities. Our members are concerned, however, that additional nursing staff may not be available, and that facilities will not be compensated for the additional nursing personnel needed to fulfill OBRA's staffing requirements.

Congress addressed sore elements of the problem by enacting nurse shortage provisions in the Omnibus Health Act of 1988. These provisions will raise financial aid to students and schools of nursing, and will establish a long-term care nurse practice demonstration project, funded by HHS grants to nonprofit collegiate schools of nursing.

A major problem remains, in which nursing facilities increasingly are unable to hire sufficient nurse personnel due to the disparity in wages between nursing facility staff and staff of other types of institutions or of private practicing physicians. According to the Commission, on average, registered nurses in nursing facilities earn 35 percent less than their hospital counterparts. Similar salary differentials exist for licensed practical nurses, nurse aides and other nursing personnel in the same area.

The current legislation, H.R. 1649, focuses on the need to offer nursing personnel, from registered nurses to nurse aides, incentives to work in the rewarding but often stressful field of care for frail, chronically ill, often elderly individuals. Its goal is to achieve parity between rates paid to nursing facility staff and staff of facilities or programs such as hospitals and home health care that pay more lucrative wages. Because the amount of increase is to be determined based on the differential between current nursing personnel salaries in long-term care and other types of facilities, the bill would enable nursing facilities to gradually raise salaries to rates that are competitive.

We support the goal of this legislation. We do, however, have some concerns with the bill as written. First, we consider that some provisions of the bill, as written, lack clarity. In particular, several key terms—"locality," "benefit," and "outside nursing facilities" would need to be defined in order to clarify the procedures to be implemented under this legislation.

Benefits may be particularly difficult to measure in a survey unless the term "benefit" is defined precisely. Health care facilities offer a variety of benefits to employees as incentives, and the type of package often depends on the market in a given geographic area. We have to be careful that limiting the mandated survey to easily quantifiable benefits does not dissuade nursing facilities from providing other types of benefits and working conditions, for example, daycare and flexitime, that might have an equally positive effect on recruitment and retention of nurse personnel.

Our second concern is that the legislation only offers one-time corrective action to bring salaries of nursing personnel in long-term care facilities in line with those in higher paid health care facilities and programs. By the time the phasein period is completed, nursing facilities would have achieved parity with four-year old salaries in similar health care settings. Parity needs to be assured on an ongoing basis if nursing personnel are to continue to be attracted to positions in nursing facilities.

Furthermore, the legislation applies only to payments made on behalf of Medicaid residents, and does not include Medicare. Thus, an adjustment is made only for Medicaid beneficiaries, and not for all beneficiaries of federal programs. The act

should include Medicare payments as well, with Medicare cost limits raised to accommodate the increase.

Finally, the legislation focuses on assuring that nursing personnel in nursing facilities are paid the minimum rate offered to other nurse personnel in the community. While this approach will ameliorate current staffing difficulties in connection with entry level nursing personnel, it will not enable facilities to attract more experienced workers.

According to a survey of nurse compensation reported in Modern Healthcare last December, the thorniest problem for registered nurses desiring to remain in the nursing field is that health care facilities do not establish career ladders or incentive pay systems that adequately reward experienced individuals or those with specific qualifications. A nurse at the top is paid very little more than a beginner in the profession. Nursing facilities have long recognized that nursing personnel at all levels need to be able to view their work with the residents as a career. They have had difficulty encouraging this attitude in their employees because of lack of financial resources. As currently written, H.R. 1649 will not help nursing facilities address this problem.

In closing, I would like to reiterate that we support the concept of this legislation—to raise the salaries of nursing personnel in nursing facilities to a level comparable to salaries of similar employees of other health care providers. While we recognize that it will take more than equity in pay to solve the nursing shortage, this bill is a significant start. It is important to stress, however, that the adjustment of nursing salaries without addressing other systemic needs of the long-term care nursing system will achieve only a limited objective. The Health Care Financing Administration [HCFA] should be required to assume more responsibility for assuring that state Medicaid programs provide adequate payment for all costs of providing care to Medicaid residents, including nursing care. In addition, HCFA should be required to update its skilled nursing facility cost limits using current data which include the increased staffing costs facilities have had to pay in recent years.

Mr. Chairman, I look forward to working with you on H.R. 1649, as well as on these other changes which are needed to assure that the Medicare and Medicaid programs make adequate payments for quality care for program beneficiaries.

Mr. WALGREN. Thank you both for that testimony.

It is certainly helpful and constructive and will help us work on this issue here.

I would like to ask a couple of questions to both of you. I would like to follow up on an issue that was raised earlier by the Chairman with Dr. Harrington of the first panel, relating to an experience in California.

Dr. Harrington noted in her testimony that on at least two occasions when California provided additional funds for nursing personnel in nursing homes, the new moneys were not fully allocated to those employees. According to Dr. Harrington, some 20 percent of California's nursing facilities made no wage passthroughs at all to their nursing personnel, even though they allocated funds for that purpose.

You have argued that wage parity is certainly the number one issue that has to be addressed in retaining nursing personnel. Why then didn't some of those nursing homes in California use the additional funds provided for wage support?

Can either of your respond to that?

Mr. WILLGING. I think it is an interesting issue and there are two sides to every issue. The industry has argued one position. I know Dr. Harrington on a number of occasions has argued the other.

I think our conclusion—in working with your staff, Mr. Chairman—was that the best thing to do for a situation like that was to construct a bill where that cannot possibly happen one way or the other. In other words, under your legislation, H.R. 1649, if the moneys are not paid out to the nursing personnel, the moneys are not collected by the facility. For those cases where there is prospec-

tive system in place—that is where the additional moneys that would be required as far as nursing personnel are concerned are anticipated and put into the perspective system up front—there is also an auditing and payback provision in the bill. As you have drafted it, the situation in California—whether it happened or not—could not happen.

Mr. WALGREN. Could I ask Mr. Rodgers, as well, when you would specifically like to see us pursue a system as Mr. Willging has just said, if the moneys are not paid out for wages then they are not received by the facility, or some kind of direct payment that could never not be passed through?

Mr. RODGERS. We believe—I have to take another look at the legislation—but we believe your bill provides for that and I think that generally speaking, we would support that contention. But we thought at least by looking at the legislation, that it provided for those kinds of safeguards.

Mr. WALGREN. How did the California provision provide for the passthrough?

What failed there? Did the California provision provide for a direct passthrough?

Mr. WILLGING. I think you could refer to those provisions, if you want to use the vernacular, as the difference between a trickle-down approach and a percolate up approach.

An amount of money was provided in California to facilities with the intention that money trickle down to nurses' wages. The argument that has been raised by some is that not all the money trickled down. I believe it was 20 percent of the facilities were cited where none of it trickled down. To again use the vernacular, the way we look at the language in your legislation is, the wages would percolate up. If the money is paid to personnel it gets reimbursed. It in effect avoids the alleged situation in California.

Mr. WALGREN. All right. Then to summarize both of your statements, let me ask you if this would be a fair representation of your position.

That given the experience in California, and as well as the statement of AHCA being committed to address the parity issue, you would have no objection to amending or so constructing this bill, we hope this committee will report it out in such a way so as to insure that nurses and nurse aides do, in fact, receive the higher wages that are called for in the legislation.

Mr. WILLGING. We would not only not object, Mr. Chairman, we would support that position.

Mr. RODGERS. I think I can speak for our association in that regard, as well.

Mr. WALGREN. One way we could provide this is to amend the nursing home reform law to add an additional requirement that facilities must meet in order to participate in the Medicaid program. That new requirement would require that State facilities must pay their nurses and nurse aides in accordance with the minimum wage rate provisions established under the legislation, H.R. 1649.

I gather from your testimony that both of you would support that concept.

Mr. RODGERS. I think that that concept needs to be linked to adequate assurances that States are going to recognize those costs. I

think that the States are an important actor in this regard. The States are extremely important in terms of recognizing that cost and we have got some concerns. I think Dr. Willging also shares some of those concerns in relationship to the increase in board member suits we have seen across the country.

The provisions would be fine so long as we could get adequate assurances that the Federal Medicaid and State Medicaid recognize those costs.

Mr. WILLGING. I think the question is the guarantees the States will do what that legislation does. We had very strong language in OBRA at the outset that said these new standards had to be accommodated in State Medicaid rates.

Yet, we have—as recently as last week seen the State of California pass legislation that says that not one additional penny will go to OBRA.

That puts nursing homes in an incredible bind. We want OBRA. We think it is overdue. We know OBRA requires additional staffing. But we see a number of States saying it is a Federal bill; let the Feds pay for it.

Mr. WALGREN. The gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thanks, Mr. Chairman.

It is also the case of let's look to the Federal Government.

Of course, it is a Federal bill but the States would be required and mandated under the legislation to put up their particular share, and we know what has been happening to some of the States around the country in terms of tremendous deficits as some of it is the result of Federal mandates without Federal Government proceeding to come up with basically the money support for those Federal mandates, and this is what we are talking about here.

This bill will cost, what, $2.6 million over 5 years and that is just the Federal portion.

The fiscal impact on the States would be about the same, would it not?

Mr. WILLGING. About the same.

Mr. BILIRAKIS. Well, I am a supporter of this legislation. Assuming this legislation would take care of the wage rate differential for nursing personnel in nursing homes, would the quality of nursing homes then be improved?

Mr. WILLGING. I think there is no question the quality would be improved. If I could again point to my remarks, the premise underlying OBRA was, in fact, we needed personnel who could fulfill these new requirements in nursing homes. We needed more personnel. We needed more training for such personnel. We needed more sophistication.

I think there has been no question in the view of today's witnesses that have appeared before this panel up to this point, that the quality of care suffers when staffing is not adequate. And it's worse when staffing suffers turnover rates.

This industry defies understanding when you look at turnover rates. We are talking about an average among nurse aides of 100 percent across the country. In some facilities, we have seen as much as 400 percent of staff turnover in 1 year.

I think previous witnesses made it quite clear that that is due to some considerable extent, to a disparity of wage rates between nursing home personnel and hospital personnel.

I would also agree that wages are not sufficient for high quality care. They are necessary, but not sufficient. I think we would not disagree with some of the previous comments. Good management, a caring attitude, a recognition that one is in this business, not for the business, but to provide care—they are all important factors. You need wages along with that, but not as a substitute for that.

Mr. BILIRAKIS. You pretty much read my mind, that is what I wanted to get into. There are other problems, obviously, and this is one of them.

It is certainly a major one. I wasn't here for all of the questioning, but you know, my personal opinion is from what I see back home, and there are, so many nursing homes in Florida and in my district, in general you do a darn good job.

There are ranges, some are better than others, but in general, thank God for nursing homes. We are going through it right now, my sister being the only girl in the family has been taking care of my mother for years, ever since we lost my dad a few years ago.

But really she has reached the point where she is almost around the bend, and social services at the hospital even called me personally here to say, look, when your mother finally gets out of the hospital she is going to have to go to a nursing home, your sister can't take total responsibility.

We are all very grateful for you good people and we know you are in it to make a living, you have got to be. We are talking about raising nurses wages so they can stay in it and make a living.

Profit is not a nasty word, but, of course, we are concerned about the passthroughs being adequate and being adequately controlled.

Thank you, Mr. Chairman.

Mr. WALGREN. Thank you, Mr. Bilirakis.

Would the gentleman want to respond in any way to the gentleman from Florida?

Mr. WILLGING. I could not add to a testimonial like that.

Mr. WALGREN. It is so important to have that kind of participation in the Congress and it makes you appreciate the system of Government we have, where you—where each of us are facing the same kind of circumstances in our own individual lives that everyone of the public and all our citizens face, and it goes a long way in making the Government sensitive to being doing the right thing.

I know on this committee not just Mr. Bilirakis, but others, also, have had direct family experiences with relying on nursing homes for something that is just so central to all that they want to see life mean. I hope it will help us be as responsive as we should be.

The gentlemen from Florida is foremost in that movement.

Dr. Willging, following up on another topic that Dr. Harrington touched on this morning. She said that growth in nursing home rates charged to patients for 1989 was 11.2 percent. You point out that 72 percent, almost three-quarters, of the daily cost of nursing homes is labor. Almost two-thirds, the largest part of the labor, is in nursing personnel.

So we have the rates going up a certain percentage and we know the labor nursing costs are the largest part in that.

Did the amount of the wages and the benefits for that labor for the nursing personnel go up in proportion to the 11 percent last year?

Mr. WILLGING. I can't say it was exactly proportional but it was very close, Mr. Chairman. In fact, the data I have submitted to the committee shows that on average cost, all categories of nursing personnel went up. Yet, we still find nursing personnel making 36.4 percent less than their counterparts in hospitals.

We find that is not true, uniformly, across the country. In the Northeast, in particular, because of the incredible shortage of nursing personnel, rates have been moving up rather dramatically. With respect to LPN's in the Northeast, we find nursing homes are paying 10 percent more than hospitals.

The problem is, on a national basis, we still have that great disparity. Although we have been able to increase salaries dramatically, in many cases this has not been as dramatically as hospitals have been able to increase salaries.

I am on the board of a hospital in Maryland. We signed a new contract with our nursing personnel that had a 20 percent increase over 1 year's period of time.

We are struggling with the disparity that already exists. I would like to take some issue with the suggestion by Dr. Harrington that somehow the money is going to administration and profits. She cited statistics from two chains. What she didn't indicate was that one was a hospital chain, MME, and the other was a chain called Manor Care, which has been able to maintain profitability because it emphasizes primarily private pay patients.

One has to look at something less than selective statistics when arguing where the moneys may have gone. We know that for the industry as a whole, profitability has been very much less than in the hospital sector. We also know in terms of administrative costs, true pure administrative costs account for only about 10 to 12 percent of the operating costs of nursing homes. These dollars are not going into profits, acquisitions and administration; they are, for the most part, going into labor.

Mr. WALGREN. You mention the profitability the private pay homes, homes that focus on non-Medicaid care beds, I gather, and only accept private pay patients. Are nurses in private pay facilities paid generally more than nurses in facilities that have a large presence of Medicaid/Medicare beds?

Mr. WILLGING. On average I think you would find they are. I would have to get that data for you and submit it for the record, Mr. Chairman.

Mr. WALGREN. I would appreciate that if you would.

It is interesting to sense so much about the economics of these areas we can. If there is some way to make an observation about the levels of pay between private pay, and certainly, Medicare/Medicaid beds, that would be very helpful.

[The following information was submitted:]

AMERICAN HEALTH CARE ASSOCIATION,
Washington, DC, September 26, 1990.

RUTH KATZ,
Counsel, Subcommittee on Health and the Environment, Washington, DC.

Reference: Hearing on H.R. 1649 (Walgren, D-PA)

DEAR MS. KATZ: I am writing in response to the question posed by Congressman Walgren during the above referenced hearing held on July 20, 1990 with regard to wages paid to nursing home nursing staff and the portion of private pay residents in the facility. I apologize for the delay in getting back to you.

Our staff economist has just completed an empirical analysis of this issue using the 1985 National Nursing Home Survey data collected by the National Center for Health Statistics. A regression analysis isolated a small, positive relationship between the proportion of private pay and nursing staff wage levels. However, this relationship was never found to be strong enough to be statistically significant.

Our results indicate that observations over the full range of observed private pay proportions do not confirm the existence of a positive relationship between nursing wages and the private pay proportion. However, the data does indicate that it is much more likely that the existence of private pay residents leads to increased nurse staffing ratios, and this has been empirically confirmed by Gottesman (1974) and Bishop (1980).

I trust that this information sufficiently addresses the question posed by Congressman Walgren. If you need any further information, please feel free to contact me at your convenience.

Sincerely,

PAUL WILLGING, *Executive Vice President.*

Mr. WALGREN. Maybe there is a way to look at private pay mixed facilities with a portion of each, and those that are dominated by Medicaid/Medicare beds.

The cite of Dr. Harrington of the two nursing home chains and the—her testimony that generally nursing homes have been quite profitable in the 1970's and 1980's, is that your experience, as well, that the nursing home industry as an industry has had profitability rates somewhere in the target range, 13 to 20 percent?

Mr. WILLGING. Quite the opposite. I am always intrigued to listen to the allegations about the high profitability of this industry. We wish it were true. It is easy to provide selective statistics as Dr. Harrington has. There is national data available. She made a point of the profitability of chains. She talked about 41 percent of nursing beds being chain operated.

We have national data stemming from the Securities and Exchange Commission. We have looked at that and, indeed, the best year over the past 10 years in terms of net revenue—she also talked about return on equity. If I have $1 of equity in nursing homes, my return on equity is 100 percent. That is a meaningless figure. One should look at net revenues. Net revenues in 1985 and 1986, based on SEC data was about 6 to 7 percent. In 1988, the last year for which we have data, the net revenue was minus 1 percent. I would argue that is not a great amount of profitability.

Mr. WALGREN. Is the SEC data the only data that is available to us, the industry does not have a compilation of some kind?

Mr. WILLGING. One of our biggest problems is the lack of data. It is the only national data base we have unlike the Medicare program which is the primary support mechanism for hospitals. Medicaid is the primary support mechanism for nursing homes. We have 51 separate data bases and unfortunately, we don't have the kind of information regarding nursing homes that we have with re-

spect to hospitals, so we do look for surrogate data such as SEC data.

Mr. RODGERS. From an antidotal perspective, I might add, the American Association of Homes for the Aging represents nonprofit, not for-profit homes.

What we are beginning to experience—at least what we are hearing from our members—is that they are beginning to dip into endowments and other types of fundraising in order to support their offset, the lack of funding they might get in terms of reimbursement.

Clearly a lot of this is antidotal right now, but we do know of some facilities that had to close down because of inadequate reimbursement.

I cite the example of Little Sisters of the Poor in Michigan which had a facility and relied on years for the nuns to provide care. There weren't as many nuns going to that order. They had to go out and purchase that service on the outside market. They weren't able to do it based on their Medicaid population and were running into $40,000 a month deficit spending. They just couldn't do it. The order decided they needed to close the facility and transfer patients. Clearly, we hate to see things like that happen, especially with organizations who have devoted their entire mission to helping older people.

Mr. WALGREN. All right. Let me ask that if there is some table or view of the SEC data that you would like to submit, we would certainly appreciate that for the record.

I gather the net income is important, but return on equity over time, if it is relatively constant, is really what an investor is looking for, I would imagine, inasmuch as there may be some areas where a little bit of equity can put you in a position of generating substantial cash flow, which may not be reflected in large percentage of net income. But nonetheless, return on equity may be quite substantial.

Mr. WILLGING. There is no question. I think I would agree with you wholeheartedly with respect to the investor; return on investment is the key issue. I was speaking more whether or not there is this mythical pot of money—massive amounts of funding—that could be used to deal with some of the underlying problems facing the industry.

The one we are talking about today is the availability of funds to provide adequate reimbursement to nursing personnel. We need new dollars, new cash to be able to pay our nursing personnel adequate living wages.

Mr. WALGREN. Well, it would be helpful if you could give us some review of return on equity over time to see what this 20-year period looks like. It is useful to know those things in terms of being able to make such judgment about the stability of the industry and what resources would be available to it.

Mr. WILLGING. We would be happy to do so.

Mr. WALGREN. Mr. Bilirakis.

Mr. BILIRAKIS. Just very quickly, Mr. Chairman. It may have been asked.

Are there nursing homes, sir, which refuse Medicaid patients?

Mr. WILLGING. There are nursing homes which refuse Medicaid patients altogether. Very few as it turns out. The 16,000 certified nursing homes—certified for Medicare and Medicaid—almost all of them accept at least a percentage of Medicaid patients.

The so-called profitmaking nursing homes have a percentage in terms of their residents of 65 percent Medicaid, and 35 percent private pay. The nonprofit nursing homes in this country, of which I also represent about 1,000, have a reverse percentage. That is, nonprofit nursing homes in this country—this is data from the National Center for Health Statistics—have a Medicaid percentage of 35 percent and a non-Medicaid percentage of 65 percent.

So it is not an issue of profitability; it is not an issue of how much money one can make by not accepting Medicaid patients. I think it is a twofold issue: One, there is religious preferences sometimes in some of the nonprofit facilities. And two, one cannot in most States provide the array of services most nursing homes would like to provide if they are dependent exclusively on Medicaid rates. The higher the percentage of private pay patients, the more likely it is you can expand upon and provide the services to the patients. In other words, the private pay patient subsidizes the Medicaid patient.

Mr. BILIRAKIS. Should nursing homes have the right to refuse Medicaid patients?

Mr. WILLGING. I think until such time as Congress or the States deal with the underlying reality that most Medicaid programs do not cover the cost of providing the service, then the facilities are going to have to have the authority, the right, to generate a balance within the structure of the facility that allows them to be able to pay for the entire array of services they provide. You have got to be able to assure that the Medicaid program is, indeed, paying for the cost of service before one could mandate a first come, first serve requirement.

Mr. BILIRAKIS. Are we talking about some nursing homes that refuse all Medicaid patients? In other words, zero?

Mr. WILLGING. There are some nursing homes, I could probably find out the percentage. For the record, yes, there are some not certified at all for the Medicare or Medicaid. It's a small minority, but some are not certified at all to provide services.

Mr. BILIRAKIS. Not certified at all, but that is not the reason they refuse a Medicaid patient.

Mr. WILLGING. If you are not certified, you cannot accept a Medicaid patient. They simply prefer to participate in the private market.

Mr. RODGERS. I think Dr. Willging's statistics are accurate. I would point out from the standpoint of the nonprofit side, we don't have, as you just talked about, return on equity. Our facilities tend to be in this for a good long time and, therefore, we need to make the dollars on the service side rather than on a real estate transaction side.

So from that standpoint, I think it might explain why there is some difference in Medicaid versus private pay populations in nursing homes and the difference between nonprofit and for-profit facilities.

Mr. WAXMAN. Thank you, Mr. Bilirakis.

Gentlemen, I appreciate you testimony. I had some questions. I understand they have been asked. I was pleased to hear what you had to say. We will look forward to working with you on this issue.

Under H.R. 1649, State Medicaid programs would be responsible for paying the increased wage and benefit rates required by this legislation. Our last witness in today's hearing represents the directors of those programs and is here to discuss the potential impact of H.R. 1649 on the States and their Medicaid programs.

Ms. Elaine Fuller is director of the Bureau of Medical Services—which administers the Medicaid program—for the State of Maine. She is testifying on behalf of the State Medicaid Directors' Association, which is part of the American Public Welfare Association. As a member of SMDA, Ms. Fuller serves as the organization's Chair of its nursing home reform work group.

We are pleased to welcome you today. Your prepared statement is in the record in full. We would like you to limit your oral statement to 5 minutes.

STATEMENT OF ELAINE FULLER, DIRECTOR, BUREAU OF MEDICAL SERVICES (MAINE), ON BEHALF OF STATE MEDICAID DIRECTORS' ASSOCIATION, AMERICAN PUBLIC WELFARE ASSOCIATION

Ms. FULLER. Thank you. It is a pleasure to be here.

I would also add to your comments about who I am and who I represent. The Bureau of Medical Services does licensing and certifications of all our health care facilities and agencies.

I am also a registered nurse by training, and have a graduate degree in public administration. My career in State government in these kinds of positions, other than as a public health nurse—was in licensing and certification. For 11 years I was in charge of the many changes that took place in nursing homes during that period of time.

I want to say that the State Medicaid agencies recognize the good intentions of this bill. Certainly wages are a significant factor in recruitment and retention of staff in nursing homes. We are also concerned about the quality of care provided in our nursing facilities.

However, as you know, and I know you have heard before, State agencies and governors are opposed to further Medicaid mandates. We are already experiencing great difficulty implementing those that have been imposed in the past few years. The States are experiencing many fiscal problems of their own.

We do feel the bill is a unilaterally costly approach to a multifaceted problem, as I think some of the other speakers have pointed out. Wages and benefits are one factor contributing to the problem. But they are not necessarily answers to access, as has been shown with some other providers under the Medicaid program. Our testimony identifies some concerns about other recently passed and proposed legislation.

The general nursing shortage is a significant factor in the staff shortage of nursing facilities. Hospitals have staff vacancy rate turnover and retention problems. Nursing staff, including nurse

aides, have been found to leave to take even lower paying positions than working in nursing homes.

The bill does not propose to recognize differences in responsibility or educational level. That should be reflected in wages, and these responsibilities do differ significantly in various specialties. I would also point out the pools of different categories of nursing staff vary considerably in different settings.

The number of licensed nurses in hospitals is many times that in nursing homes. Our experience is they preen the best aides from many of the long-care term facilities, particularly when they are experiencing shortages of licensed nurses. We went through this recently in the State of Maine. They were not using nurse aides in hospitals for several years. As they experienced shortage of licensed nurses, they started using nurse aides.

Using wages paid to aides in hospitals as a standard for wages in nursing homes is not fair, because that is just simply going to drive up the costs since hospitals do pay more to nurse aides; we know that. But they don't use anywhere as many nurse aides.

I would also point out a point made by someone else. A wage increase cannot be attributed to staffs serving Medicaid recipients, as this bill proposes. Rates for Medicare and private pay patients would have to reflect those increases. Recoupments are easier said than done. Recoupment negates the underlying premise of the prospective reimbursement system. That is a system 95 percent of the States use for paying nursing homes. It also causes some problems during the time you are recouping funds, because that takes away from the operating capital for a nursing facility.

The timeframes of the bill for a State Medicaid agency are quite impossible. We need adequate staff for doing the required surveys. It is an additional burden for States and providers to complete that information, to analyze the data, develop levels. We would have to change regulations and statutes, and we would have to seek legislative appropriations. There is absolutely no question about that. We cannot possibly do those things within the 6 months this bill would allow.

In our testimony we suggest some other remedies for staffing shortages such as nursing education issues.

I would like to talk about what Maine has done about the shortage of nursing staff. I would agree with a lot of the comments made here today about the outcomes of poor care and the impact on staff. I would also point out that in order to change the patterns of care in nursing homes, you have to educate the nursing staff, not simply give them more money. You also have to bring them up to speed on current standards of care and get them to change how they care for patients in long-term care facilities. That comes back to some basic nursing education issues.

Maine did a study of nursing aides back in 1986 and 1987. We have two reports that were prepared—I have copies with me if anybody is interested in them. We found a turnover rate of 64 percent at a time when we were experiencing shortages. We have required aide training for many years, and in fact, the study found the turnover rates were greater in homes with a higher per diem rate and in homes that did not show a profit. For some reason, they showed a higher turnover of staff.

Wages were deemed by administrators as the major reason for the shortage. They talked about career opportunities.

We also had a nursing commission that looked at licensed nurses' issues as they related to our health care delivery system.

I would be glad to answer any questions. Thank you.

[Testimony resumes on p. 167.]

[The prepared statement of Ms. Fuller follows:]

STATEMENT OF ELAINE FULLER ON BEHALF OF
STATE MEDICAID DIRECTORS' ASSOCIATION, AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. Chairman, members of the Committee, I am Elaine Fuller, Director of the Bureau of Medical Services in Maine. I am here today to represent the State Medicaid Directors' Association (SMDA) of the American Public Welfare Association. I serve as the current chairwoman of the SMDA Nursing Home Reform Work Group and as a member of the SMDA Executive Committee. I am a Registered Nurse by training with a graduate degree in Public Administration. Prior to becoming the Medicaid Director, I spent 11 years in charge of the Maine Office of Long Term Care Facility Licensure and Certification. This office is responsible for ensuring that nursing facilities comply with all applicable federal and state statutes and regulations. My experiences have made me keenly aware of staffing issues and quality of care concerns in these facilities.

On behalf of the SMDA, I appreciate the opportunity to speak with you about H.R. 1649. This bill would require state agencies to provide nursing facility rate adjustments to finance wage and benefit increases for nursing-related personnel in these facilities in order to raise the nursing facility wage and benefit minimum to a level equal to the average wages and benefits of nursing personnel working in other settings within a locality.

State agencies are concerned about improving access to health care services for the poor and are equally concerned about the quality of the care provided. The experience of many states over the years has shown that increased funding levels do not always reap improved access or quality of care. Because of this experience, State Medicaid agencies have several concerns

about this bill. Our concerns run the spectrum from general issues regarding the approach of the bill, to the practicality of specific concepts embodied in the bill, and finally to the technical issues surrounding implementation of the provisions of the proposal.

THE APPROACH OF H.R. 1649

As I am sure you are well aware, the vast majority of state agencies and governors stand in opposition to further mandated Medicaid expansions. The number of federally imposed mandates since 1987 have been exceptional -- nursing home reform, coverage of Qualified Medicare Beneficiaries and Qualified Working Disabled, several expansions in coverage of children, infants and pregnant women, changes to disproportionate share hospital reimbursement, and greatly expanded services under the EPSDT program, to name a few.

State governments are having considerable difficulty funding all the new expansions in eligibility, services, and regulatory requirements such as nursing home reform. State agencies are having extreme difficulty meeting rapidly changing program requirements within very short time frames without adequate federal agency guidance. Sound public policy requires thorough planning at the state level which is not possible within Medicaid at this time due to the scope and nature of recent federal mandates.

H.R. 1649 represents a potentially costly mandate that causes state agencies great concern. In addition to our general position on mandates, we are concerned about the orientation of the bill and whether or not it would truly achieve the desired goal. In times of fiscal restraint at the state level, policy implications, costs and outcomes must be carefully weighed. While the

concept of this bill is relatively simple -- pay more to a certain segment of health care workers -- the implementation would not be nearly so facile. In addition, the costs of this proposal would be substantial in many states. Given the general parameters of the problem, we are not convinced the approach of H.R. 1649 would represent money well-spent.

State agencies are increasingly concerned about recently enacted and proposed legislation which require unilateral approaches to multi-faceted problems when the outcome is not certain. The OBRA '89 obstetric and pediatric provider adequate payment provision is an example. SMDA believes that this requirement will not address key factors affecting physician participation such as: malpractice costs; geographic distribution of providers; red tape resulting in large part from federally imposed requirements; and the percieved difficulty of treating Medicaid clients. Clearly, provider participation is a complex issue, but OBRA '89 requires Medicaid to pay these providers at rates that will assure client access on par with the insured population in a geographic area. It is not at all clear that this is possible around the country, but states will expend considerable resources on uncertain outcomes, given the diversity of factors that give rise to the problem.

Provisions of the Community and Facility Habilitation Services legislation under consideration by this Subcommittee also represent this type of singular approach. The bill would require establishment of minimum federal compensation guidelines for providers of home and community based services. The bill would stipulate that the compensation guidelines assure reduced turn-over of direct care personnel. This provision assumes payments are the most

significant factor and seemingly ignores all the interactive recruitment and retention issues which cannot necessarily be accounted for through payments rates.

H.R. 1649 represents a similar approach. Staffing shortages and high turnover rates in nursing facilities are related to many diverse factors. The bill seems to presume that wages and benefits are the major cause of staff shortages and turnover. State agencies do not concur with this analysis. Government intervention in setting wage levels for certain workers can thwart the incentives that a marketplace philosophy provides such as work environments, educational level, staff development, and opportunities for advancement.

Nursing facility operators have found that several other means of attracting and retaining nursing staff can be equally important including: the provision of on-site child care; allowing flexible work schedules for weekends or schedules to accommodate people who wish to work less than forty hours per week; full tuition reimbursement for training; emphasis on career development and advancement; development of 'tailored' benefit packages which allow employee choice among benefit type and scope; and transportation assistance of various types. Nursing facilities should be allowed to design various compensation packages, working within the context of state minimum wage laws and other state requirements.

Creative methods of addressing the nursing personnel shortage are being developed and employed to varying degress. New approaches are necessary given the nature and causes of the recruitment and retention problems.

NURSING PERSONNEL SHORTAGES

The SMDA believes that nursing facility staff shortages cannot be viewed in isolation. There is a general shortage of nursing personnel across the nation in all health sectors. We question how this bill could address this larger issue through its singular focus on Medicaid payment to nursing facilities. It is the larger problem of RN, LPN and nurse aide availability on a system-wide basis that will continue to plague nursing facilities. While the studies cited as the basis for this bill highlight nursing facility nurse aide turnover at 70% to 100% per year, RN turnover in acute care hospitals has been shown to be as high as 200% in some hospitals.

Nursing personnel turnover is due to a variety of dissatisfactions, many of which are more causal than wages and benefits. Although hospitals have a difficult time recruiting and retaining RNs, LPNs, and nurse aides, it appears that the nursing facility problem is exacerbated because there is less interest in the field of geriatric long term care then there is in provision of acute medical care. In addition, there is a high degree of 'burn-out' associated with provision of geriatric long term care. In a certain sense, the patients can be difficult to care for given the nature of their illnesses and disabilities. Patients frequently do not 'improve,' given their age or illness which does not always provide the care giver with a sense of satisfaction. The work is frequently routine and does not constitute cutting-edge medicine nor life and death treatment.

The highly institutional setting of a nursing facility and the constant pressure to comply with rigid paperwork requirements can pose recruitment and retention difficulties. The highly structured delivery of routine care required to meet certification standards can also be

detrimental to recruitment and retention. These types of nursing facility staffing issues lead to a further state agency concern about the impact of nursing home reform on facility staffing since the thrust of the law imposes greater institutional requirements of the type that staff already cite as a major source of dissatisfaction.

Anecdotally, Minnesota has found that nurse-aides often leave nursing facilities to work for lower wages in adult foster care. Nurse aides have stated to state agency staff that the foster care work allows greater freedom of interaction because worker/patient relations can be less structured. The foster care system often recruits their nurse aide staff from nursing facilities. Clearly wages are not the issue here. We are further concerned about the potentially adverse impact on staffing of the highly regulated approach to community care, as expressed in the optional community care proposals before this Subcommittee. Of particularly concern is the potential effect on the adult foster care system.

FISCAL IMPACT ON THE HEALTH CARE SYSTEM

H.R. 1649 does not seem to acknowledge that nursing care in different settings means highly different things. Long term care is technically less demanding than ER, OR, or ICU nursing care. Should this differential in responsibility be reflected in wages and benefits? What will a rise in the wage and benefit floor for less demanding care services do to medical cost inflation as the whole pay scale moves upward? It could be highly inflationary to annually adjust nursing facility personnel wages and benefits to the wages of personnel in other settings -- whose wages presumably would increase annually to maintain pay distinctions and continue the recruitment edge of non-long term care settings. Indexing nursing facility wages could

adversely affect some of the other sectors that use similar personnel, such as home health agencies. Some of these agencies rely on United Way funding and client contributions for significant revenues and therefore cannot readily raise salaries and wages. The pool of different categories of nursing staff is also a significant consideration. The number of licensed nurses in hospitals is far in excess of those employed in nursing facilities; conversely, the number of nurse aides in nursing facilities far exceeds those in hospitals. Most hospitals use very few nurse aides and in fact may recruit many of the best nurse aides from long term care settings because they can offer higher wages to the smaller numbers. When a hospital hires a nurse aide at a higher wage than a nursing facility, it is still paying a lower wage than if it had recruited a licensed nurse. This bill does not address the realities of the labor market and would drive up costs substantially.

We do not believe Congress should mandate wage levels when wages are not the central issue and then anticipate that significant problems will be resolved. More money into the system is not always prudent nor does it always represent a true solution to the problems at hand. Several states have pay comparability within parameters of job responsibilities and the like. Others have included wage increase pass throughs in their rates. There is little evidence to suggest that these measures have resolved the problems recognized in this bill. We would urge Congress to study the larger problem and to work with state agencies and the health care industry to devise strategies that address the broader problem of nursing shortages.

TECHNICAL ISSUES

Implementing a proposal such as H.R. 1649 would carry substantial indirect costs due to its administrative complexity. It may be difficult to determine an incremental wage increase that accounts for staff time in the care of only Medicaid clients in a facility. The bill seemingly places no responsibility on Medicare to adjust per diem rates for wage increases although presumably, wage and benefit increases would have to be allowed for Medicare reimbursement. Such changes in Medicare and Medicaid could further drive up the cost of care for private pay clients. The cost of nursing facility care is already escalating at an alarming rate, resulting in quicker spend down for private pay residents and earlier coverage of these people under Medicaid while placing additional costs on already limited funding.

This proposal raises other questions as well. Are states to account for differential responsibilities for nursing personnel among various care settings? If so, this can be difficult. The bill does not seem to acknowledge that nursing personnel vary considerably in educational level despite carrying the same job title or certification. Further, how would benefits be accounted for in a locality where a university associated teaching hospital may offer relatively low wages which are offset by an educational benefit that equals thousands of dollars annually but which effectively costs the hospital nothing? Should such educational benefit costs be included in the state base?

Monitoring how a per diem add-on for increased wages and benefits is distributed among individual staff of the nursing facility will be impossible in some current state reimbursement

systems where the facilities report facility averages. Whole reimbursement systems, methodologies, and reporting systems would have to be changed in order to comply.

Recoupment of NF funds for hard to prove overpayments will be difficult. Recoupment will place the state/provider relationship on a highly contentious footing. There is considerable room for the states and HCFA to disagree on facility overpayments as well. More broadly, we are concerned that the bill's recoupment provisions could undermine the basic premise of a prospective reimbursement system.

Finally, the bill would require submission of state plan changes within three months of enactment. Presumably a state would have to survey health facilities in all localities, hammer out wage/benefit parity issues in order to analyze the survey data, develop new nursing facility staffing wage and benefit levels, possibly change state statute and/or regulation, seek legislative appropriations, develop a monitoring mechanism, and notify all NFs, all within three months of enactment. This is a Herculean task set within impossible timeframes. Congress tends to establish mandates and provide inadequate timeframes in which to comply. While Congress may not always be concerned about whether states are ready on the specified date and may wish only to light a fire so that the task is soon accomplished, short timeframes leave states liable for sanction from the federal agencies and subject to lawsuits from various sectors for failure to act in a timeframe which was impossible from the start. We would request that Congress respect the size of the tasks it requires and not place states in a difficult position.

ALTERNATIVE APPROACHES

Rather than wage adjustments for one specific sector of the industry, Congress may want to consider broader reform that addresses the larger issue of general availability of nursing personnel. One approach would be to take stock of the nursing-related shortage from a broad, supply-side perspective. Congress may want to consider ways to recruit more people into the field.

The federal government could look at targeting dollars for more student loans for nursing education. There could be funding incentives for enhancing the geriatric/long term care component of basic nursing education. Similarly, a program of loan forgiveness could be instituted for nursing personnel working in the field of geriatric care. Money could be provided to teaching hospitals for better recruitment programs in high schools for nursing education in general or to highlight geriatric nursing in particular.

Finally, funds could be allocated for improved career development opportunities. Encouragement through funding could be provided for current nurse aides to train to become LPNs and then finally RNs.

SUMMARY

The problem this bill seeks to address is complex because of the many factors that actually constitute the total problem. We urge Congress not to take a potentially costly, singular, approach to such a multi-dimensional issue.

State agencies are concerned about quality of care in nursing facilities and have tried a variety of approaches to address the issue of concern of this bill. We remain committed to working with Congress to explore possible alternative approaches.

Thank you for the opportunity to be here today and to comment on this bill.

Mr. WAXMAN. Thank you very much.

Ms. Fuller, you state in your written testimony that "the experience of many States over the years has shown increased funding levels do not always reap improved access or quality of care". Can you document this with some specific examples? If the increased funding does not improve the quality of care, what does it do?

Ms. FULLER. It does not necessarily improve the quality of care for some of the other reasons mentioned. You still need to upgrade the qualifications of the staff, the education of the staff to bring them up to speed on current standards of practice.

There are also other barriers for access to health care. Our comment in our testimony pertains not only to nursing homes but to some of the other services funded under Medicaid, such as access to physician services or dental services. There are many other factors involved as to why providers are not going to accept Medicaid patients even if we pay them more. I have heard this in the State of Maine and elsewhere.

Mr. WAXMAN. I want to follow up on a point made by Ms. Burger, on our first panel. She argued the greatest barrier to quality of care was understaffing. She went on to say that "nursing homes are limited by how many staff they can hire by State reimbursement systems that place a cap on direct nursing care expenses".

I can understand why States would want to limit the rates of increase in their Medicaid nursing home payments. But I don't understand why they would want to place caps on what, from the standpoint of quality care, is the single most important component of nursing home costs: direct nursing care.

Could you explain these caps to me. If they lead to understaffing, why do States impose them?

Ms. FULLER. I am not exactly sure, Mr. Chairman, what the caps were the previous speaker was referring to. Can I tell you there are many States, as I indicated, that are on a prospective reimbursement system which, in fact, does limit what they are going to pay to nursing homes. The increase is basically an inflationary increase.

To some extent, there is a cap when you have a prospective reimbursement system. Within that cap, facilities can use that money according to their best judgment of where they want to spend it.

The other issue is the Medicare upper limit. I don't know if that is part of the reference to the cap that was being discussed or not. Even for intermediate care facilities under the Medicaid program, we are subject to living within the Medicare upper limit. To some extent that has served as a cap, but not on individual salaries or categories of staff.

I will tell you in the State of Maine we have had provisions for approving additional staff in nursing homes when facilities say we have now heavier care patients and we need more staff. We have criteria for going in and doing levying and authorizing additional hours. We have made many adjustments in the nursing staff in nursing homes in the recent years to do that.

Mr. WAXMAN. So there are no specific caps, then?

Ms. FULLER. Not that I know of.

Mr. WAXMAN. Mr. Walgren.

Mr. WALGREN. Thank you, Mr. Chairman.

You indicated that 95 percent of the States use prospective payment systems and yet Maine removed its prospective payment system for nursing wages and benefits for some time. What is the experience there? When did Maine do that?

Ms. FULLER. Maine implemented a prospective payment system in 1983 and 1984. When the nursing shortage hit back in 1986 and 1987, we made many adjustments in the per diem rate to nursing homes to allow them to grant wage increases to staff. And then following that, because that was an extremely difficult process, we were doing it on facility by facility basis.

We did find as we looked at wages built into the rate that the inflationary increase that had been granted in the per diem rate over that period of time was 20.8 percent. The actual unaudited average statewide increase in wages was 9.5 percent for CNA's and 18.5 percent for RN's that was under the prospective system.

We did the adjustments in 1987 and 1988. In 1989, we went on a retrospective system for wages only. Our reimbursement is partly prospective, but wages are 70 percent of the cost of nursing home care. If you pull out wages you have fixed costs, which are capital and certain other. You don't have a whole lot left.

But in 1989, because of the staffing problems, the wage problems—Maine had been experiencing for several years an extremely high unemployment rate—we were on the retrospective payment system. Our wages for RN's went up 16 percent, LPN's 17 percent, and CNA's, 14 percent.

That was at substantial additional cost to the State of Maine which is one of the States in the Northeast that is suffering serious fiscal problems. The wages did go up. We are going back on a prospective system this year as facilities start their new fiscal year. That was passed in the legislature. Nursing homes want it. We are going back on a prospective system so the only increase they will get is an inflation increase.

Mr. WALGREN. Nursing homes want it, but don't you run a danger of walking back into the low-wage situation?

Ms. FULLER. I think that is a real possibility. I think that is a major concern.

I would also point out the importance of the regulatory process to make them get that staff. As we have started posing some of the enforcement remedies the Nursing Home Reform Act gives us—rather then closing facilities we can impose other remedies—I think there will be more pressure for nursing homes to provide better quality care and for the regulatory process to work better.

Mr. WALGREN. Thank you very much, Mr. Chairman. I appreciate it.

Mr. WAXMAN. Thank you, Mr. Walgren.

Ms. Fuller, thank you very much for your testimony.

That completes the hearing today. We stand adjourned.

[Whereupon, at 12:40 p.m., the hearing was adjourned.]

[The following statement was submitted:]

PREPARED STATEMENT OF MARTHA MCSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE, SOCIAL SECURITY AND MEDICARE

Mr. Chairman, I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. As they are of an age where they are potential consumers of nursing home services, our nearly five million members have a strong interest in the quality of care provided in such facilities.

So we are pleased that you are holding hearings on Congressman Walgren's H.R. 1649 to set Medicaid reimbursements at a level where nursing facilities can pay their staff salaries competitive with hospitals. We fully support this legislation. Better wages tend to attract a better, more stable staff, and that, in turn, leads to a higher quality of care. The Pepper Commission too recommended higher Medicaid reimbursement for nursing homes.

The National Committee also supports H.R. 1650, Mr. Walgren's bill to require that Medicare and Medicaid certified facilities provide registered nursing services 24 hours a day, seven days a week. With these two pieces of legislation we begin to address the dismal staffing situation in many long-term care facilities. Many nursing homes are not adequately staffed to care for today's frailer and sicker residents. Patients released earlier from hospitals require more care, so there is a greater need for skilled care in nursing homes.

Nursing care is what one expects from a nursing home and yet in many facilities, that is not what the consumer gets. The 1987 nursing home reforms took an important step in requiring licensed nursing staff 24 hours a day for all nursing homes. But since an RN is required only 8 hours a day and nursing homes can apply for waivers to this requirement, further action is needed. Also Congress has yet to set a minimum nurse aide staffing pattern.

When Mr. Walgren proposed 24 hour RN coverage in 1987, the committee voted it down, ostensibly because the current nurse shortage made it an impossible requirement to meet. Clearly one good reason for the nursing shortage—especially in nursing homes—is low wages. It is estimated that RNs in nursing homes earn 35 percent less than RNs in hospitals.

Work in nursing homes can be very gratifying when there is enough staff time to provide good care and give individual attention to residents. But all too often, staff is stretched too thin and supplemented with temporary help unfamiliar with the daily routine in the facility. Temporary staffers are often resented by the permanent staff because their pay is higher—further lowering morale in the facility. The result is staff burnout—residents snapped at, hurried, neglected or abused. H.R. 1649 would help attract good nursing staff and diminish the need for temporary agency help.

Better care is not free. The Congressional Budget Office estimates H.R. 1649 would increase Medicaid dollars spent on nursing home staffing by 31 percent. The full effect of the bill would not be felt until 1994 when it will cost the federal government $2.6 billion and state governments $2.1 billion. Because states are experiencing the considerable challenge of recently mandated Medicaid expansion, the question arises whether the federal government should increase, in the initial years, its share of the implementation of this legislation. The 1987 Nursing Home Reform legislation sets a precedent for this by increasing the federal Medicaid share of the cost of nurse aide training.

The National Committee strongly supports the payback provision in H.R. 1649 which would require facilities to apply the increased reimbursement to nursing staff salaries or return the money to Medicaid. This safeguards against the use of these extra dollars for general operating costs. However, legislative or regulatory language should spell out exactly how oversight of the payback provision will be carried out.

In addition, we caution that better wages must not become a tradeoff for using fewer nurses, LPNs or nurse aides. We need better wages and we need more direct caregivers and staff to supervise the care provided by these caregivers.

There is an expanding need for qualified nurse staffing so nursing homes can provide care for older, frailer and sicker residents. And H.R. 1649 would ease the difficult time nursing home administrators are experiencing in securing adequate staff.

○